Caring here, caring there: Boston-based black Immigrant caregivers as agents of the globalization of eldercare

O'Leary, Megan Elizabeth

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Boston University
Approved by

First Reader

Nazli Kibria, Ph.D.
Professor of Sociology

Second Reader

Julian Go, Ph.D.
Professor of Sociology

Third Reader

John Stone, Ph.D.
Professor of Sociology
DEDICATION

I dedicate this work to my endlessly supportive and loving parents Daniel and Cynthia O'Leary, my sister and best friend Erin O'Leary, and the love of my life Kwame Lewis.
ACKNOWLEDGMENTS

Recognizing the diverse interpretations of “the family” and what it means to care lies at the crux of this work. As exhibited in stories of bonds between caregivers and clients and of the love that transcends borders between immigrants and their relatives abroad, it is clear that caring roles and relationships can be established beyond the confines of blood relations. To me, family means having a strong support network that enhances your emotional, physical, and mental wellbeing. These individuals will celebrate your victories and empathize with you on your darkest days. They push you to be a better version of yourself, but remind you of your own strength and capabilities. Degrees of closeness may vary and roles of support may be diverse, but each person in your network shares a meaningful role in enhancing your life. For nearly ten years, my graduate career has taken a central role in my life – shaping my relationships and my identity. Through the ups and downs, I had a strong support network – a family by blood, marriage, friendship, and school – that pushed me to complete my degree and produce meaningful and impactful research.

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Anna Bakanova and Keryn Egan who help with important organizational details that too often go unnoticed, to the faculty members who have awarded me with fellowships, research assistantships, and teaching opportunities. Each person played a significant role in helping me reach my goals and deserve my sincerest appreciation.

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I consider myself lucky to have such a tightknit and loving family be my biggest supporters and closest friends. I am deeply grateful to my grandparents, both alive and those who have passed, for always cheering on my intellectual pursuits. (I think this achievement would have made the “clipping service!”) The presence of my aunts, uncles, and cousins (in person and in spirit – WWDD)
always brings light and happiness to my heart. It is safe to say that I could not have gotten through this without my sister, Erin O’Leary. I could always depend on her to listen, laugh, and keep it real with me. I could not ask for a better sister or friend. My parents, Cindy and Dan O’Leary, deserve the title of “the ultimate caregivers.” Their immeasurable love and support has allowed me to grow, thrive, and become the person I am today. I am amazed at all they have done for me and I am incredibly lucky to have them as parents. Finally, I am forever grateful for my husband, Kwame Lewis. His love, encouragement, and care have made me a better person. There is no other person I would want to share my journey with as I begin the next chapter of my life.

I also want to acknowledge the people, institutions, and agencies that opened their doors to me and helped me access participants so that I could conduct this important research. Most of all, I want to thank the caregivers who trusted me to tell their stories. I hope the rest of society can see the important roles they play in bettering the lives of those around them and reward them for their immensely difficult work. Their emotional and physical care sustains an entire generation, day after day, and they change the world just by doing their jobs.

To my family, now and then, near and far: thank you.
CARING HERE, CARING THERE

BOSTON-BASED BLACK IMMIGRANT CAREGIVERS AS AGENTS OF
THE GLOBALIZATION OF ELDERCARE

MEGAN ELIZABETH O’LEARY

Boston University Graduate School of Arts and Sciences, 2016

Major Professor: Dr. Nazli Kibria, Professor of Sociology

ABSTRACT

This dissertation explores the transnational care perspectives and practices of black immigrants working on the frontlines of eldercare in Greater Boston. Responding to the critical shortage of caregivers for the burgeoning aging population, first-generation immigrants from African and Caribbean countries find work in this field, performing physically and emotionally grueling work as Home Health Aides and Certified Nursing Assistants for low pay and few benefits. At the same time that these caregivers provide the most intimate care for older Americans and adults with disabilities, they often take on caring responsibilities for their aging relatives abroad. Evidence from fifty in-depth interviews with African and Caribbean caregivers reveals that these immigrants are changing the climate of eldercare in the U.S. as well as in their countries of
origin by providing eldercare-specific economic and social remittances to their families abroad and fictive kinship through creative emotion work for their clients in the United States. These practices are informed by their transnational social location and work experiences which expose these caregivers to different state systems and care cultures. A dual evaluation of the perceived strengths and weaknesses of national eldercare systems produces for them a general definition of compassionate eldercare as the delivery of life saving medical care and skillful emotion work that ensure elders feel dignity in body and mind. Along with perceived cultural differences, these caregivers identify income inequality and weak welfare regimes as producing atmospheres of resource deficit and emotional deficit in the countries of origin and country of settlement, respectively. These perceptions provoke these caregivers to attend to the observed deficit and provide well-balanced compassionate care for their dependents, whether family member or client. These immigrant caregivers derive a sense of agency and pride from “filling the voids” in care for their clients and family members, arming them with a positive transnational caring identity strategy that helps guard against racism and marginalization they often experience on the job. Taken together, these findings reveal new ways of
thinking about eldercare best practices and illustrate how actors at the micro level can inform institutional change at the global level.
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LIST OF ABBREVIATIONS

ADLs ............................................................................................ Activities of Daily Living

CCRC .................................................................................. Continuing Care Retirement Community

CNA .................................................................................... Certified Nursing Assistant

DON .................................................................................... Director of Nursing

HHA .................................................................................... Home Health Aide

LPN .................................................................................... Licensed Practical Nurse

RN ....................................................................................... Registered Nurse

SNF ....................................................................................... Skilled Nursing Facility
CHAPTER ONE: “You Will Save People Here, You Will Save People Back Home”: Transnational Caregiving from Boston to Beyond

In 2009, a team of noted policy researchers compiled a report for the Immigrant Learning Center, Inc. based in Malden, Massachusetts entitled, “Immigrant Workers in the Massachusetts Health Care Industry: A Report on Status and Future Prospects.” Within the report, the warning of an impending critical demand on the healthcare sector echoed what many popular media outlets have written about over the past decade – the “graying” of America and the shortage of workers to care for the nation’s elderly.¹ Advancements in medical technology and the sheer number of retiring baby boomers have put pressure on eldercare services around the country, with Massachusetts “ranked 12th out of 50 states in the percent of population 65+ years in 2000 and 10th in the percent of population 85+ years” (Borges-Mendez et al. 2009:12). Compounding the projected shortage of eldercare workers is the lack of the appeal of frontline work in eldercare compared with other more lucrative subfields in the healthcare sector, thanks to low pay, few benefits, and physically and emotionally grueling

tasks (Duffy 2011; Stone and Wiener 2001).

As Evelyn Nakano Glenn (2010) describes in her book, *Forced to Care: Coercion and Caregiving in America*, caring in the United States has not always been viewed as a public concern. As middle class American women moved into the paid workforce, their traditional roles of caring for children and aging relatives became institutionalized as a low paying segment of the U.S. economy. Hochschild writes, “Seventy-two percent of all American women now work. Most also work longer hours for more months a year and for more years, and hence badly need help caring for the family” (Hochschild [1997] 2009). Care that once took place in personal homes is also increasingly taking place in facilities such as daycares, nursing homes, and assisted living facilities. While home care initiatives have been set up where people can receive paid services in the comforts of their own homes, the work has been transformed from informal caring by relatives to organized services, often performed by immigrants working within the specialized niche.

As American baby boomers came of age during the second half of the twentieth century and women went to work, the world around them changed as well. Political and economic systems of nations across the globe became more interdependent through technological advancements, transnational business
activity, and large-scale migrations of people across borders. Entire industries collapsed across the United States; financial and service sector jobs opened up in the absence of blue collar manufacturing plants (Sassen 2000). In the 1980s, the economic climate of developing countries in the Caribbean, Africa, Latin America and Asia transformed dramatically. Debt-ridden countries were held to financial standards and repayment regimes structured by international organizations such as the International Monetary Fund and World Bank.

Along with changes in the political economies of developed and developing countries, social and cultural climates changed as well (Parreñas 2005). Such ideological changes were reflected in and reinforced by the passing of the Hart-Celler Immigration Act of 1965 which opened up U.S. borders to developing countries that were previously restricted due to race-based National Origins quotas. Responding to the altered economic opportunities, U.S. immigration legislative changes geared towards work and family reunification, and bombarded with images of the promise of success, or at the very least, survival, people from countries in the “Global South” migrated to the United States. Similar to other historical waves of immigration, these new immigrants brought with them ideas and traditions to introduce to the receiving population (Portes and Rumbaut 2006). Many new immigrants began to fill the demand for
low-skilled service positions in the newly restructured U.S. economy (Sassen 2000). In the Northeast Region of the United States, white and African American women who moved out of the healthcare sector and into other jobs in the new economy were replaced by new immigrants particularly from the Caribbean and Africa – creating the foundations of a racialized niche in the frontlines of elder care that persists today (DeJesus 2009; Kibria, Bowman and O’Leary 2014; Waldinger 1996).

Thinking transnationally, this movement of Caribbean and African immigrants into paid caregiver positions has many implications for eldercare both in the Greater Boston area and in the immigrants’ countries of origin. As people move from developing countries to more developed countries to work as low-skilled nursing assistants and home care workers, a new social organization of labor forms in both the sending and receiving countries (Ehrenreich and Hochschild 2002). This dissertation investigates the transnational care dynamics of fifty first-generation African and Caribbean immigrants who work as paid caregivers for the elderly in Greater Boston. It explores the social and economic consequences of this particular link in the global chain of eldercare by focusing on the care perceptions and care practices of black immigrant nursing assistants and home care workers. My findings reveal that these immigrant caregivers are
changing the climate of eldercare in the U.S. as well as in their countries of origin by providing eldercare-specific economic and social remittances to their families abroad and fictive kinship through creative emotion work for their clients in the U.S., exhibiting power amidst structures of marginalization both in and out of work due to their race, gender, and immigrant status. Stories from these caregivers illustrate how the practices of individuals can contribute to processes of economic and cultural globalization.

Three specific goals of this dissertation are to understand how the experiences of immigrants working in eldercare in the United States shape both their perceptions and care behaviors for their aging relatives in the countries of origin and their perceptions of their own cultural contributions toward eldercare in the United States; to uncover how work context – institutional settings versus paid in-home care settings – influences perceptions, practices, and identity formation for these immigrant caregivers; and to illuminate how race and foreign-born status shape the relationships these caregivers have with their clients and their identities as exceptional caregivers.

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2 I use the term client interchangeably with resident and patient to describe paid care recipients. The participants in this study often used such terms interchangeably as well, likely due to the fact that many held jobs in both home and institutional settings.
RESEARCH QUESTIONS

Through fifty in-depth interviews with African and Caribbean elder caregivers in the United States, I explore how the experience of caring for the elderly in a paid care setting in the United States impacts black immigrants’ perspectives on caring and their actual care behavior for their own parents and aging relatives in the global care chain. Additionally, in questioning their perceptions of these different eldercare settings, I attempt to uncover how their cultural values translate into the work with American senior citizens. Research questions central to this dissertation are: What are the perceptions of Caribbean and African immigrant eldercare workers toward the eldercare system of the United States? What are the perceptions of these immigrant caregivers toward types of caring for aging relatives in their countries of origin? How do these perceptions and values shape the type of care they practice towards their parents and aging relatives? Alternatively, how do these perceptions and values translate into the physical care and emotional labor they practice in their jobs as paid caregivers for U.S.-based elderly clients? I argue that by virtue of their absence from their countries of origin, caregivers in this black immigrant niche change the landscape of eldercare in sending and receiving countries through their perceptions of caregiving work and their actual care behavior.
The formal eldercare industry in the United States is complex in that a growing number of options are available for people tasked with deciding where and how to spend their old age. With home care becoming a popular alternative to residence in nursing home institutions in recent decades, elders can elect to receive help with Activities of Daily Living (ADLs) “such as eating, dressing, bathing, and toileting” in addition to “housekeeping chores, meal preparation, and medication management” from home care aides (PHInational.org 2011). While qualitative sociological studies have explored the experiences and values of workers in either nursing homes or as home care aides (Diamond 1992; Foner 1994; Ibarra 2010; Rivas 2002; Stacey 2011), this dissertation explores how the type of formal care setting (nursing home care or in-home care) impacts Caribbean and African immigrant caregivers’ perceptions of their work and their feelings toward caring for elders in their countries of origin. Therefore, a subsidiary research question is: In what ways are perspectives on the U.S. eldercare system similar or different for home care workers and nursing assistants in institutions, and are these differences reflected in the ways these

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3 I use the term “formal care” to refer to both paid caring for elders in institutional settings such as nursing homes and paid caring for elders in private homes as home care workers and home health aides hired through agencies. By using this terminology I’m following Clare L. Stacey’s distinction between formal care and informal care in her book, *The Caring Self: The Work Experiences of Home Care Aides*. She defines informal care as “the unpaid care provided to family members and friends, generally in the home” (2011:19).
caregivers think about caring and care for elderly in their countries of origin? These questions stem from an assumption that in-home care may be more compatible than nursing home care with the cultural values of these caregivers when thinking about feasible care options to implement in the future.

I also highlight comparison cases to observe the intersection of gender, foreign-born status, and cultural norms on the perceptions eldercare workers have concerning the U.S. eldercare system and the eldercare system in their countries of origin and their actual care behaviors. Although women comprise almost ninety percent of the direct-care workforce according to a 2008 study by the Paraprofessional Healthcare Institute, any men who enter the occupation tend to be men of color and foreign-born (Glenn 2010; PHInational.org 2011; Stacey 2011). The establishment of eldercare as a female ethnic niche coincided with global economic changes beginning in the 1960s and the Hart-Celler Immigration Act of 1965, which removed the racially motivated National Origins quota system that had severely limited migration from the Caribbean and Africa for several decades. Henke (2001) writes:

For example, many of [these American middle-class women] left hospital nursing to better-paying and more prestigious positions in the private sector (Toney 1989). The same mobility also created a demand for services, such as general domestic helpers or caregivers for children, the elderly, and even for pets. These jobs were typically closed to men who, in addition, suffered from the
decline in industries (e.g., manufacturing or trades) they had traditionally been able to join upon arrival in the United States. (P. 31)

Arlie Russell Hochschild (2009) recognizes that such transitions in the global economy have created a “growing ‘care industry’ [that] has stepped into the traditional wife’s role, creating a very real demand for migrant women”… and as “the unpaid work of raising a child became the paid work of child-care workers, its low market value revealed the abidingly low value of caring work generally – and further lowered it” (pp. 3–9). Furthermore, the tasks of providing emotional support, nursing assistance, and caring for elders, have traditionally been defined as feminized professions in the United States. The emotional labor involved in establishing a relationship with clients and the physical tasks such as bathing and dressing clients stigmatize the occupational category as a female domain. Researchers focusing on the labor shortage of eldercare workers have discussed the feasibility of recruiting more male nursing assistants to fill the void, but growth in this sector remains low due to its stigmatization, undervalued reputation, and low pay/benefits (Cottingham 2014). This work explores how the perspectives and care practices of these Caribbean and African male immigrants working in eldercare compare with the perceptions and practices of Caribbean and African female immigrant caregivers. Subsidiary
research questions exploring these dynamics are: How do cultural gender roles impact Caribbean and African eldercare workers’ perceptions of caring responsibilities and caregiving practices? How does working in a caregiving field impact Caribbean and African immigrant male perspectives toward caring roles? Are these men performing the same types of tasks as women or are the genders segregated in terms of tasks and type of eldercare (institutional versus in-home)? What role does immigrant status play in the identity options of black immigrant men working in a traditionally female sector? More specifically, do “Sojourner Statuses” allow these men to cope with the marginalization effects other American men might perceive in a female-dominated profession (Arthur 2000; Woldemikael 1989)?

THEORETICAL AND PRACTICAL SIGNIFICANCE

These research questions yielded important contributions in theory and practice that extend beyond the discipline of sociology. The global focus of the research circumvents the typical Western-centric views of the eldercare industry and its workers, allowing the reader to understand the dynamic of immigration as both an agent and consequence of economic and cultural globalization. While their perceptions about care responsibilities were largely grounded in evaluations of states and cultural norms at the transnational level, taken together,
this black immigrant niche in carework (a byproduct of years of structural racism combined with immigrant networking) affects change in nations across the globe. Similarly, perceptions concerning care responsibilities and practices for senior citizens in the United States also benefit from the different (but often overlapping in practice) country-specific cultural ideas that infuse their constructions of emotion work and compassionate, holistic eldercare.

The stories of these immigrant caregivers provide an empirical example of globalization at the ground level: specifically, how transnational activity is shaped by broader economic and social change, and how it, in turn, affects change. For most of the participants in this study, their first encounter with the United States involved seeing mass-media-produced images of New York City, hearing stories of relatives living and working in Miami, and feeling the absence of their own relatives who migrated and made it through the cold winters of Boston years before their own migration journey. In other words, these immigrants possessed some familiarity with the United States by virtue of living in an increasingly globalized and interconnected world. They face their life and work experiences armed with an arsenal of images of what to expect and they often adjust their expectations upon confronting the trials and tribulations of reality in a new country. They use whatever economic, social and cultural
capital they brought with them to navigate new experiences and learn the unfamiliar “rules of the game.” Oftentimes, this involves settlement decisions based on where family, friends, or members of the same ethnic group have located; finding work through these networks regardless of past occupational experience; and the continuous maintenance of social ties with family and friends in the countries of origin.

The women and men in this study define what it means to be transnational citizens: living and working in the immigrant-receiving country while continuing to maintain familial, social, economic, and in some cases, political relations in the sending countries. They inhabit what Glick Schiller and Fouron (1990) call a transnational social field, or an “unbounded terrain of interlocking egocentric networks” characterized by a variety of “egalitarian, unequal, and exploitative relationships that often encompass immigrants, persons born in the country of origin who never migrated, and persons born in the country of settlement of many different ethnic backgrounds” (p. 344). In Bourdieusian terms, immigrants’ identity formations and perspectives are shaped by their experiences living in this transnational space, whereby an individual’s habitus, or “internalized dispositions, schemas, and forms of know-how” is influenced by his or her biography and access to different types of
capital, which in turn alters practices that engender new means of socialization (Swartz 2002:62S). Thus, while immigrants’ perspectives and perceptions of life chances are largely informed by their early childhood socialization into the social order of the countries of origin, different ways of thinking and being can occur as immigrants encounter novel situations where “dispositions of habitus do not fit well with the constraints and the opportunities of fields (situations)” (Swartz 2002:65S). New experiences in the United States and more specifically, work in the eldercare field, shape participants’ perceptions towards the systems, roles, and eldercare practices in their home countries. More than just sending economic remittances to their countries of origin, these immigrant caregivers transmit social remittances: “norms, practices, ideas, and identities” to their networks in the sending countries (Levitt and Lamba-Nieves 2011:1).

Alternatively, they impart new ideas and practices to people in the United States through social interactions. This circulation of knowledge production has important consequences for globalized practices of eldercare, whereby best practices of different polities are integrated, imagined, and initiated by individual actors. A transnational optic on social fields takes into account the globalized nature of institutional isomorphism at a macro level, while allowing for a methodological entry point to study how immigrants construct identities,
perceive the outside world, and engage in practices at the micro level (Glick Schiller and Fouron 1990). These caregivers live in this in-between state of “simultaneous incorporation,” where their caring practices work to create new ways of thinking about geriatric care that extend beyond personal transnational family relationships to communities in both country of origin and country of settlement. These practices then engender new situations that continue to influence caregiving – resulting in an evolving and emerging transnational field specific to the practices of eldercare.

At a less abstract level, this research is significant in that it provides an outlet for the voices of the frontline caregivers for the aged whose perspectives tend to be overlooked, dismissed, and devalued because of their position on the lower rungs of the deeply stratified nursing hierarchy. The nursing assistants and home care aides that work with American elderly in this study characterize their relationships with their clients as one of closeness and attentiveness. To be sure, when time allows for caregivers to attend to the nurturing aspects of emotion work, these caregivers have the most personal and prolonged contact with the aged. Even in institutions that value chartable tasks over emotional bonds, these caregivers go above and beyond to understand the needs of their clients and fulfill those needs in ways that account for preserving dignity and
wellbeing. Despite these efforts, these HHAs and CNAs report having minimal agency in care regiments, inadequate compensation and benefits for their efforts, and they often experience a devaluation of their work, a narrative common to caregivers across time and place (Boris and Parrenas 2010b; Diamond 1992; Ehrenreich & Hochschild 2002; Foner 1994; Glenn 2010; Hondagneu-Sotelo 2001; Rivas 2002; Stacey 2011). Following the tradition of Dorothy E. Smith (2005) in recognizing and confronting the dominance of the ruling classes, interviewing foreign-born women and men of color calls into question the taken-for-granted dominant ideas on the structure of eldercare. Students of Smith have employed her theoretical assumptions and methods to dissect how institutionalized concepts often ignore or interfere with the lived experiences or standpoints of marginalized groups (DeVault 2011). For example, Timothy Diamond (1992) questioned how the daily work of caring for elders in nursing homes has been “defined and reproduced day in and day out as a business” and how the “terms of exchange that make up an industry – productivity, efficiency, labor, management, ownership, stocks, profits, and products” sometimes fail to take into account the actual needs of the clients and the skills of the caregivers (pp. 4–5). Taking Diamond’s institutional ethnography of nursing home caregivers one step further, this dissertation questions how the perceptions and practices of
these Caribbean and African immigrants both impact and are constrained by the broader institutions of eldercare. Because I wanted to see how the institutions of care are altered or maintained by both the practices of care work by immigrants in the U.S., as well as the care work for the aging populations left behind, these assumptions about power and agency inform my analysis on how the beliefs and practices of individuals change the practices of eldercare institutions. By incorporating the perceptions of these immigrant caregivers into the discourse on eldercare in the U.S. and in immigrant sending countries, innovative concepts and ideas about compassionate caregiving emerge and, if heard, can contribute to new ways to care for the aged across the world.

By asking Caribbean and African immigrant caregivers about their perspectives on eldercare and their strategies for providing physical and emotional care to their U.S. clients and indirect care to elders in their countries of origin, my research addresses how members of this particular marginalized population become agents of action in an atmosphere of inequality and structural constraints. It helps provide the story from the standpoint of black immigrant caregivers whose voices are often ignored amidst an often hostile U.S. political and social climate of anti-immigrant and racist rhetoric. The perspectives and care work of immigrant caregivers have practical implications for both the elders
that are cared for by these caregivers directly in the U.S. and for the elders left behind in the countries of origin (Hochschild 2009). As baby boomers and their children plan for their long term care in the future, and as the aging populations, caregivers, and policymakers work with the care deficit in the sending countries, understanding the impact of the values and the caring behaviors of immigrant caregivers will be essential to imagine who will care for the aged and what that care will involve in the future.

RELATED LITERATURE

Globalization of Care

This dissertation speaks to the growing body of works on the global chain of care – ideas made prominent and popular by researchers such as Arlie Russell Hochschild, Barbara Ehrenreich, and Rhacel Salazar Parreñas. Situating care work in a context of political, economic, and social inequality among nations is essential as the world becomes increasingly interconnected in the age of globalization. Parreñas (2005) charted the impact of neoliberal reforms such as Structural Adjustment Programs on the changing economic and social climate of the Philippines that set off the migration of Filipina mothers to become nannies for American children. Similarly, Saskia Sassen (2000) has explored the broad changes in the global economy that have altered the social and economic climates
of developing countries as well as created a bifurcated structure of high skilled financial and low skilled service work in more developed economies like the United States. She explains how this uneven global economy has encouraged people, especially women, to move from their countries to fill the shortages in low-skilled American jobs. As workers cross borders, new ideas and practices cross with them.

By examining the experiences of immigrant care workers and the significance their absence has on the eldercare climate of the Caribbean and African countries from which they originated, my research extends a field of work that is dominated by generic views of “immigrants of color”. When research focuses on specific cases of the care chain, such as Pierrette Hondagneu-Sotelo’s (2001) work with Latina immigrant workers, or Rhacel Salazar Parrenas’ (2005) work with Filipina mothers on contract work in the U.S., Caribbean and African experiences and viewpoints have not been the focus. Not only does my research contribute to providing a voice for these groups of direct-care workers, but it also focuses on an interesting dynamic of culture, race, gender and immigration that cannot be captured in a study of caregivers in general. Additionally, most of the focus within these works tends to be on the relationship between immigrants who come to the United States to work as paid
caregivers for American children and the children they leave behind under a relative or nanny’s care in their home country. Although eldercare is often mentioned as part of the care chain, few studies have looked in-depth at the consequences for both the immigrant caregiver and the elderly left in the country of origin. To help formulate the research questions of my dissertation, then, I employed concepts from literature on the experience of immigrants working in the eldercare industry in the United States, as well as concepts from works within the care chain literature that focus on the role of culture, gender, and race to understand how working in the U.S. care industry influences care practices for aging relatives in the sending countries.

_Perspectives on the Eldercare Industry of the United States_

As news reports began to decry the shortage of eldercare workers and criticize the lack of compassionate caring and poor treatment of the American aged in nursing homes at the hands of their nursing assistants, researchers in the social sciences became curious about the true nature of the work and workers that were facing criticism. Sociologist Timothy Diamond (1992) used participant-observation to observe the dynamics of nursing home care in *Making Gray Gold: Narratives of Nursing Home Care*. Diamond found that nursing assistants constantly had to grapple with the demands of caring for the individual in an
environment that stressed efficiency, the medicalization of care work, and the
treatment of nursing home patients as passive recipients of chartable medical
tasks. While Diamond (1992) did not investigate the sending countries of the
predominantly immigrant care force he worked with during his time as a
nursing assistant, one quote from a caregiver reveals a particular idea of cultural
differences that fueled assumptions behind my study:

A nurse from a foreign country had just finished a contentious encounter with a
resident, and frustration showed on her face while she tried to make sense of this
most confusing social organization. “Oh, these people make me so mad,” she
said. “But there’s one thing that makes me even madder – their families! If their
families hadn’t abandoned them, they wouldn’t be here. In my country we don’t
even have nursing homes. Our families take care of their old.” She was
expressing an idea that was widely shared, by people native to the United States
and its immigrants – that people live in nursing homes because they have been
abandoned by their families. (P. 70)

Within this passage, the sense of cultural differences in caregiving emerges from
the discourse of the foreign-born nursing assistant. The participants in this work
share a similar outlook, but the narratives are far more nuanced as they reflect on
their own separation from their families and the time-crunch factors they
encounter by working in a low paying occupation.

An essential part of the direct-care literature explores the dynamic
between effective emotional labor and the bureaucracy of commodified elder
care (Diamond 1992; Foner 1994; Ibarra 2010; Zelizer 2005). Similar to Diamond’s
study, Nancy Foner explored the intersection between bureaucracy and compassionate care in her study of a New York City nursing home. Her investigation of the hierarchies of power within the staff of the nursing home indicates that nursing assistants tend to be marginalized in terms of their say in care regiments, although they spend the most time with the residents. Foner’s study also illustrates that most of the low-skilled nursing assistants tend to be from marginalized populations reflecting the large numbers of black West Indians living in New York City, while most of the higher level staff members were white Americans (1992:17). While many of the nursing assistants in her study found ways to implicitly resist management’s decrees, and conduct personal care and sensitive emotional labor, the nursing assistants who were most valued by administrators tended to be those who were most efficient with their tasks. While the efficiency model is valued by nursing homes, home care workers tend to have a vastly different experience in negotiating the levels of emotional work and physical labor demanded by the job (Stacey 2011). In her book, *The Caring Self: The Work Experience of Home Care Aides*, Clare L. Stacey (2011) utilizes Hochschild theory of “feeling rules” to indicate the importance context makes on emotion work. Stacey writes, “Workers, such as aides, who provide care or other services at the nexus of home and work prompt an
exploration of emotional labor in what Hochschild identifies as ‘marketized private life,” a third sector of social life that exists awkwardly between the realms of family and work” (2011:62). As such, home care workers often become frustrated if they feel obligated to perform more care work than the job description entails. Alternatively, Ibarra’s (2010) study of Mexican private elder care workers (as opposed to the agency-hired in-home aides that Stacey interviewed) highlights the intrinsic value these workers feel in establishing close relationships with their clients, regardless of what might be considered “extra work.” My research takes these studies on the intersection of culture and commodified care work one step further by looking at the impact of their care perceptions on the countries of origin: How does their emotional labor and physical work become transformed into care for their parents and aging relatives abroad? How do these actions change the value of the care provided by immigrants to their parents and aging relatives in the sending countries? The works by Foner, Diamond, Stacey and Ibarra on the caregivers’ experiences of care work inform the assumptions and theoretical underpinnings of my study greatly, but my research broadens the impact by exploring the perceptions and practices of different types of care workers – nursing home assistants and home care aides side-by-side.
Given that many of the participants in this study have worked or currently work in both home and institutional care settings, they are able to speak to the strengths and weaknesses of the different work contexts. Ultimately these caregivers reach a consensus on the importance of providing a balance in delivering both emotion work and physical work for their clients and families. Additionally, they desire a balance between providing more time to devote to care relationships in homes and institutions while also stipulating clear definitions and standards of the job to prevent exploitation. These caregivers value both physical and emotion work, and as such view holistic healthcare, or taking care of the “whole person” emotionally and physically, as the best means to provide quality care regardless of the work context or the nature of the bond to the recipient.

The Intersection of Gender, Race and Immigrant Status in Caregiving Here and Abroad

In their Introduction to the *Global Woman: Nannies, Maids, and Sex Workers in the New Economy* anthology, Barbara Ehrenreich and Arlie Russell Hochschild (2002), point out that research on the globalization of care work has ignored the role of men. Using this point to raise consciousness of the unequal pressure placed on women to perform care work, Ehrenreich and Hochschild call for the demand for fathers to participate in caring, because as Hochschild articulates in
her essay, “Love and Gold,” it is with their lack of help that the “care drain’ truly begins” (Hochschild 2002:29). Through a historical analysis that traces caregiving from its roots in indentured domestic work to the paid immigrant women caregivers of the present day, Evelyn Nakano Glenn (2010) also examines how informal and formal care work has become the domain of women. In addition to examining the larger global economic and political inequalities, Glenn highlights policy and U.S. court cases that have served to devalue the cost and importance of care work as an essential women’s task. She illustrates how broader structural forces have served to create a low-paying niche that is composed of women and people of color. Like Ehrenreich and Hochschild (2002), when men enter Glenn’s (2010) discourse, it is through the role of male companions that essentialize care as women’s work and contribute to its devaluation.

My research extends the discussion of the role of males in the global care chain narrative by exploring the feelings and behavior of males who do work in caregiving. Because these males tend to be from marginalized populations, i.e. foreign-born, men of color, my research questions whether working in caregiving serves to reinforce the marginalization of men of color. I illuminate the strategies these Caribbean and African men use to preserve a positive identity while
working as caregivers. Ultimately, their responses are quite similar to the women working in the field – they highlight their prowess at providing skilled holistic care for their clients and families. Where they diverge slightly, however, is in explaining why they excel at their jobs and how they determine their caregiving responsibilities: while some women claimed their skills to be intrinsic and natural to their gender and took on sole responsibility of providing for their families, these men and many of the women interviewed elevated the role of the “interdependent culture” of their homelands. These questions regarding gender responsibilities and care behaviors also contribute to studies that have been conducted on the subject of gender roles in performing filial piety for elders that are separated from their immigrant children (Lan 2002; Kodwo 2009). Lan explores the tradition of filial piety within the global care chain and finds that the actual practice of care is often transferred from the male son to the daughter-in-law, and often from the daughter-in-law to a paid careworker (Lan 2002). Therefore the responsibility of care rests in the women’s domain. Exploring the intersection between gender and remittance activity from immigrant children to

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4 In her research, Pei-Chia Lan (2002) explains the importance of the tradition of filial piety in Chinese families. She writes: “Child rearing is viewed as a process of social investment with an expectation of delayed repayment, or in Chinese, bau-da (payback). Parents undergo economic and emotional costs in bearing and raising children, this tradition stipulates, so children, especially sons, are obligated to return the debts through provision of care for their aging parents” (Lan 2002:169).
their parents overseas, Stephen Raymond Kodwo’s (2009) dissertation finds mixed gender roles in amounts of remittances sent and concern expressed for aging relatives, citing a complex constellation of familial, economic, and migration factors as shaping remittance activity. By viewing males and females in the same earnings and labor market position, my study controls an independent variable that could affect remittance and caring activity by focusing more on how the nature of the work impacts feelings about caring for their aging relatives in the sending countries.

Research on Caribbean and African immigrants working in low-skilled positions in the United States often shows that these groups emphasize their immigrant or “sojourner status” to cope with the marginalization they might feel in the labor market in terms of compensation and social exclusion or racism. Arthur (2000) finds that “immigrants engage in comparative status negotiation in which statuses and roles are determined by the material and non-material levels of status-identity relative to the status-identity they were culturally accustomed to while living in Africa (p. 88). In her book, *Black Identities: West Indian Immigrant Dreams and American Realities*, Mary Waters cites John Ogbu’s theory that West Indian immigrants are able to cope with racism and discrimination because they are “voluntary minorities” who “use their home country and
culture as a frame of reference” (Waters 1999:142). By exploring how these caregivers construct positive caring identities, then, this research shows how unique social locations, in this case that of the black transnational caregivers, inform experiences and identity strategies that might not be available to other groups. Results from these interviews confirm the utility of using the homeland as a frame of reference, particularly when confronted by racism and marginalization at the hands of their bosses and the nurses that watch over their work. It was less often used as a strategy when encountering racism by clients. Alternatively, in order to preserve the feelings of fictive kinship with clients, these caregivers used other strategies to interpret racism such as medicalizing the behavior allowing them to frame the attacks as an aberration and preserve the “family ideology.” Through examining the agency of these women and men in both changing the caring atmosphere of the United States and in their countries of origin, the carework literature receives a much needed analysis of the strategies that transnational caregivers use directly or indirectly to resist marginalization, despite the minimal compensation and value they receive for

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5 Waters explains that Ogbu distinguishes between West Indians as “voluntary minorities” who chose to migrate to the U.S. for opportunity with African Americans as “involuntary minorities” who were brought to U.S. through slavery, in order to explain the race relations between these two groups and how they each look at racism and the labor market of the United States (1999:142).
their efforts at work.

Finally, by fusing together the literature on transnational childcare chains with the research on geriatric carework, it is clear that elders and children call for different styles of care. Unlike the focus on preserving nurturant “mothering” bonds in the burgeoning literature on transnational childcare chains, the perceptions and practices of these immigrant caregivers reveal that construction of ideal care for senior citizens incorporates an equal emphasis on emotion work in “ensuring dignity” as it does in providing the skilled medical care and physical ADLs required to assist a population vulnerable to physical and mental declines. These perceptions of compassionate care do not bemoan the interconnectedness of intimacy and economic activity or view love and money as hostile separate spheres (Duffy 2011; Hochschild 2002; Zelizer 2005). Alternatively, this story celebrates it; by living in this transnational space, these immigrants recognize the delicate balance between material resources and the ability to provide compassionate holistic eldercare practices, which they do not consider to be mutually exclusive. Their vantage point as immigrants displaced from their families and as caregivers filling the roles of overworked children of their clients suggests to these immigrants that a balance of emotion work and advanced medical techniques (ideally supported by state social protections to
ensure more equitable distribution) form the standard of care these caregivers hope to provide for their clients and family members. To be sure, these immigrants highlight idealized family relationships, but their varied experiences and own work pressures in the U.S. force them to reconcile the notion that eldercare incorporates both economically-backed medical care and familial or pseudo-familial presence to ensure the dignity of seniors in their care.

In an ideal world, social protections would be provided by states for aging residents who no longer work or need assistance in other forms; economies would provide well-paying jobs with enough paid leave and shorter schedules to spend time with loved ones; quality healthcare would be available and accessible with an emphasis on caring for the “whole person” – the mental, physical and emotional components that make up quality of life; training would be frequent; and compensation would reflect the great skill that goes into providing emotional and physical carework for the elderly. These caregivers believe in an economically sound and culturally-sensitive political environment that takes care of the aged by accounting for their physical and emotional needs to provide them with dignity. When they fail to see this definition coming to fruition, they fight against a weak economy or government inaction in their countries of origin to provide medical care and they get creative with tight schedules in U.S. caring
institutions in order to provide emotion work and important ADLs. In doing so, these immigrants are acting as agents of transnational care. Some push political boundaries, while others act on a more micro level. Furthermore, while they are actively negotiating their caring responsibilities, these caregivers often face threats to their own identity and personal goals. Redefining eldercare as the delivery of skilled holistic compassionate care opens the door for a less gendered, and subsequently devalued, idea of carework. A more “professionalized” view of care as a skill provides these caregivers with pride and has the ability to safeguard them from racism by clients, racism by staff, and by classed comparisons in their countries of origin.

*Summary of Chapters*

The next chapter provides a brief overview of the national direct care workforce that serves the demand for paid caregivers. I include in-depth information on my sample and methodology, describing my recruitment of caregivers through the home care agency and the lengthy and difficult process of recruiting institution-based caregivers. I describe the potential impact of my social position in relation to my sample population amongst other strengths and limitations of the study design, and my reasons for using qualitative methods to answer questions about perceptions and practices. I also incorporate a
discussion of my data analyses, including the process of coding for concepts, themes, and comparisons using NVivo software.

Chapter Three, “Comparing Care: Perceptions of Eldercare Systems from a Transnational Optic,” explores how these caregivers construct ideas of caring responsibilities for their clients in the Greater Boston area and for their families in the countries of origin. Through comparing the strengths and weaknesses of care systems, these caregivers produce a general definition of compassionate eldercare – which, to them, means the delivery of life saving medical care and skillful emotion work that ensure the elder feels dignity in body and mind. Specifically, their perceptions concerning the relationship between the political economy and provision of eldercare, the availability of and access to medical technologies for seniors in each country, and general observed familial roles and responsibilities in providing care, help them to identify which aspects of care need to be met in order to achieve this form of holistic compassionate eldercare. They recognize limits on caregiving imposed by income inequality and weak welfare regimes that produce atmospheres of resource deficit and emotional deficit in the countries of origin and country of settlement, respectively, and their perceptions provoke these caregivers to attend to the observed deficit and provide well-balanced care for their dependents, both for family and for the
clients they consider fictive kin.

Chapter Four, “Managing Medical Care across Borders: Transnational Family Care,” investigates the consequences of care migration for the aging relatives “left behind” in the countries of origin. As outlined in Chapter Three, participants’ perceive governments in sending countries as lacking in the provision of social services and advanced or accessible healthcare. Their disillusionment with the sending country governments, particularly in the Haitian population subset, increases their feelings of personal responsibility to care from afar. This chapter, then, looks at the roles of these transnational caregivers in transforming the economic and social climates of care in their homelands. It discusses the unique contributions of these immigrants in sending eldercare-specific remittances – vitamins and medical equipment such as pull ups, walkers, wheelchairs. In addition to sending money to help manage care, food, and these in-kind remittances, participants also share ideas and tips with their family members and communities on hygiene, CPR, and lifting immobile elders. Participants also discuss encouraging aging family members to migrate to the U.S. for healthcare purposes, but many describe the struggle of achieving a balance between managing their intense work schedules and providing the emotional care they feel their recently migrated family members deserve – falling
into the same time-crunch they complain about in regards to the U.S. care system.

Chapter Five, “Filling the Emotional Void: Delivering Dignity to Clients in Boston,” explores how these immigrant caregivers think about and practice compassionate holistic care for their clients in Greater Boston. Stemming from the idea that the treatment of the elderly population by the U.S. social welfare and healthcare system is largely positive, but that U.S. culture lacks communal values and familial emotional support for elders, participants emphasize the importance of “being there” for their clients to provide basic ADLs and emotional connection. In other words, they view themselves as fictive kin who provide that missing compassion and love to their clients. This chapter explores the paid work of caregiving and details themes of emotion work that resonate throughout the interviews and the ways work context shapes the execution of emotion work. Findings reveal that time pressures set by Medicaid reimbursement structures in the institutional contexts forces caregivers to be creative with emotion work. Caregivers in institutions interpret activities that may be commonly associated with physical ADLs as bodily tasks essentially infused with love that evoke very real emotional consequences for the client. Therefore their definition of emotion work highlights the intricate methods of
touch and the intimacy of cleaning the clients as mattering greatly for preserving the client’s sense of dignity. This emphasis on achieving emotional benefits through both relational and physical labor corresponds to their goal of providing the missing piece to achieve holistic healthcare for elders in the United States.

Chapter Six, “‘Like a Dog in Their Backyard’: Race, Xenophobia, and the Transnational Caring Self” explores the role of work and caring context on caring identity formation and showcases the divergent ways these caregivers tackle prejudice when it emanates from their clients versus from their coworkers. It develops the concept of the “Transnational Caring Self”: an extension of Clare Stacey’s (2011) examination of the “caring self” in her pivotal work on the experiences of home care workers in California. Through a parallel exploration of home care work and institutional care work by workers that have experience in one or both settings, this chapter elucidates the importance of context and exactly how the minimal autonomy, understaffed shifts, and tense coworker relations that characterize institutional care settings threaten positive identity creation. I find that despite the threats to the caregivers’ identities by coworkers and bosses, these black immigrant caregivers understand their value as filling the emotional voids for their clients and filling the material needs for their aging relatives and other family members abroad. This transnational orientation
provides these caregivers with alternative identity strategies that help them save face and preserve their pride as “caring selves” when they encounter oppressive situations. With clients, caregivers attempt to overlook racism by ignoring and excusing verbal and physical abuse in order to maintain the close familial bonds they view as central to the caregiver-client relationship.

Chapter Seven, “The Globalization of Eldercare” summarizes the findings of the previous chapters and revisits the idea of using transnational social field theory to explore how ideas and practices are shared across borders impacting how we can think empirically about globalization at a ground level. These immigrant caregivers base their practices on their ongoing evaluations about the governments and family support systems in sending and receiving countries. Their identities and practices are not located statically in one polity, but rather these immigrant caregivers incorporate information and affect change in both polities. This transnational behavior has far reaching impacts on policy – including the migration of aging relatives to the U.S. and settlement choices for retirement. Additionally, these caregivers suggest best practices on eldercare that can improve compassionate caregiving across borders, noting from experience the significance of time, love, and affection on the well-being of their elderly clients and the importance of publicly funded accessible healthcare for
their families. Their suggestions are reflective of a warm-modern model of care as described by Arlie Russell Hochschild (2003) that ultimately caregiving should be composed of a mixture of informal and formal (institutional) care, with both genders taking part in caregiving, flexible work-time schedules, and an increased value of care and recognition for the caregivers who provide it.
CHAPTER TWO: Methods

Megan: What do you think the U.S. could learn from Kenya?

James: To be thankful for what we have…as much as you might think it is not great, we should be very thankful. To be more willing to work with diverse people, to try and see where they come from. Like now, if I did not put my story out there, would somebody have known it? No. I feel like people should go revisit all these poor countries and you’ll come back so humbled, so broken down. You probably won’t throw away that little piece of bread that is at the end because it’s hard and crusty. You’ll chew it and probably crush it and eat it however, not waste food. When you see a senior citizen out there getting on the bus, you are going to get up and give them your seat. When you live next to an elderly person, time to time, you go and check on them and clean their driveway, let them know if they need anything, my name is so and so, here is my number. I think also teaching people that where we’re from, what we’ve gone through, I think that would go a long way, don’t you think?

James smiled shyly as he said this - just barely overpowering the sounds of holiday music, the clangs and whizzes of a coffee maker, and the giggles of teens waiting in line at the coffee shop nestled in the local bookstore. At the outset of the interview, James had remarked that he was happy to participate as a token of reciprocity for the scholarship he received from our mutual acquaintance who knew of my research and encouraged him to contact me. He said he was surprised that anyone would be interested in his story, but he was honored to help. Throughout the interview, James exuded humility as he spoke about his life. He detailed growing up as the only son of a single mother who,
reflective of her position in the sandwich generation, was also tasked with taking care of the needs of her own frail mother. James was content in his country – spending time with his tightknit group of friends from college while working in the lab of a local hospital. It was not until a friend brought to class a stack of photocopied applications for the Diversity Visa lottery and urged the group to give it a shot that James’s life would change dramatically and he and his wife would end up in the United States. Since his arrival, James has worked in countless jobs – from a cashier at a department store to years as a Certified Nursing Assistant before becoming a Registered Nurse. He is currently at school working towards his Bachelors of Science in Nursing. James was able to climb the ladder of upward mobility in nursing in the U.S. – a feat few other participants in this study or few others in the direct care sector of the workforce have been able to do (Bercovitz et al. 2011; Diamond 1992; Glenn 1992).

To write of James’s occupational success is not to say it was without challenges or to discount the parts of his story that resonate with many of the other responses of black immigrants facing discrimination from their communities, their clients, and their staff members. It was not until we discussed what James meant by Americans learning to work with diverse groups that James began to grow more outwardly confident in the value of his story.
His is just one example of many experiences of these caregivers that rarely get told in the age of “color-blind” racism for fear of being labeled as a complainer or playing the race card (Bonilla-Silva 2003). Aside from his discussion of discrimination were illustrations of pride in his work, suggestions on how to better the eldercare systems of the U.S. and his sending country, and what he feels he contributes to his clients and his own family – themes that resonate throughout all fifty interviews in this dissertation. These are the stories of the caregivers that are not often heard because they rarely get asked. These are the portraits of the caregivers as people who are more than just one-dimensional immigrant workers. These are the people who are building relationships with and caring for America’s senior citizens. These are people who, reflective of their biographies and their work in eldercare, bring unique perspectives on caregiving that shape their real or imagined best practices. By virtue of their transnational social location and their impacts on their clients and their families abroad, these are the agents of the globalization of eldercare. These are the stories I knew were important to hear. But as a middle class white American doctoral student with roots planted several generations deep in Massachusetts, would I be able to tell it?

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THEORETICAL UNDERPINNINGS: QUALITATIVE METHODOLOGY

When I set out to answer the research questions outlined in the previous chapter, I wanted to provide an outlet for the voices of immigrants who work as caregivers for the elderly in Greater Boston. The nursing assistants and home care aides that work with older Americans and adults with disabilities tend to have the most personal and prolonged contact with the aged, yet they have the least amount of agency in care regiments, minimal compensation and benefits for their efforts, and they often face a devaluation of their work (Boris and Parreñas 2010; Diamond 1992; Foner 1994; Glenn 2010; Rivas 2002; Stacey 2011).

Alternatively, stories abound about abuses at the hands of the caregivers, whereby concern for the welfare of American elders dictates the narratives on the state of nursing homes and community-based care initiatives (Foner 1994). As news articles warn of a shortage of workers to care for the graying baby boomer cohort, the paid caregivers they seek to retain and recruit are portrayed as nameless and faceless entities. Despite recent initiatives by the U.S. Department of Health and Human Services to administer national probability sample surveys on nursing assistants and home health aides to find out reasons for turnover and encourage better policies for worker retention, the structured survey questions fail to provide rich description and open-ended responses from the participants.
(Bercovitz et al. 2011). Interviewing foreign-born women and men of color, then, calls into question the taken-for-granted dominant ideas on the structure of eldercare that often ignore the standpoints of marginalized groups (DeVault 2011). By incorporating the perceptions of these immigrant caregivers into the discourse on eldercare in the U.S. and their sending countries, innovative concepts and ideas about compassionate caregiving emerge and contribute to new ways to care for the aged across the world.

This study rejects the notion of globalization as a one-directional process of Americanization on the worker and the nature of work (Held et al. 1999). By examining the issues through a transnational framework centered on the perspectives and behavior of immigrant caregivers, the empirical evidence informs the transformationalist theory of cultural globalization that attempts to offer the cultures of the periphery with a voice in how cultural globalization becomes incorporated into their lives. Researchers such as Appadurai (1990), Barber (1995), Hannerz (1992), and Tomlinson (1991) recognize the ability of people, communities, and nations to negotiate the levels at which they choose to incorporate new phenomena and ideals with past indigenous traditions and forms of identity. In this study, I examine how perceptions and practices of caring for elders are negotiated when cultures collide within the U.S. eldercare
industry and with the transmission of caring ideas and practices from immigrants to their families overseas. Additionally, in asking Caribbean and African immigrant caregivers about their perspectives on eldercare, their strategies for providing physical and emotional care to their U.S. clients, and indirect care to elders in their countries of origin, this research addresses how members of this particular marginalized population become agents of action in an atmosphere of inequality and structural constraints.

Based on these assumptions and the Pragmatist ontological beliefs that “knowledge is created through action and interaction” and that “‘reality’ cannot be divorced from the operative perspective of the knower” (Corbin and Strauss 2008:2–4), I decided to conduct qualitative research. My research methodology is based on the fundamentals of grounded theory developed by Glaser and Strauss (1967) that presumes theory and concepts are constructed by researchers “out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves” (Corbin and Strauss 2008:11). Thus, qualitative research allows for the researcher to understand processes of knowledge and identity formation and in the case of my particular research, it provides a space for the authentic perspectives of the participants that are shaped by their unique family,
migration, and work experiences. In other words, to address questions of how
Caribbean and African immigrants perceive and how these perceptions influence
how they act, I conducted formal in-depth interviews with the participants to
understand how they construct reality. In order to check that my own
constructions of the responses did not overshadow the authenticity of the
participant’s voices, I practiced self-reflexivity and re-evaluation with the
concepts and theories throughout the process of data collection, memo writing,
and analysis.

SAMPLE

My justification for understanding the experiences of Caribbean and
African immigrants working in eldercare arose not only from the perceived
necessity of revealing the voice of marginalized groups, but more importantly,
stems from the practical existence of a black immigrant niche in this area of work
(Bashi 2007; Glenn 1992; Kibria, Bowman and O’Leary 2014; Vickerman 1999).
Domestic work and the establishment of the nursing aide category by the Red
Cross in the 1930s have long been domains of racial and ethnic minorities barred
from accessing other sectors of the labor market (Glenn 1992). More recently,
immigrants have filled the direct care workforce with twenty-one percent of
The Times feature reported that of the total 372,900 foreign-born workers in the “nursing aides, orderlies, and attendants” category of the U.S. Bureau of Labor Statistics, 34,900 workers are from Jamaica, 33,900 are from Haiti, 19,000 are from the Dominican Republic, 10,400 are from Guyana, 7,400 are from Trinidad and Tobago, and 7,400 are from Nigeria. The concentration of black immigrant workers in eldercare is even more prevalent in the Northeast region and specifically, the Greater Boston area, than in other parts of the country. An article by Kyoung-Hee Yu indicates that “staff working for Haitian community organizations reported informally that over 70 per cent of the 41,000 nursing assistants working in Massachusetts in the year 2000 were Haitian” (2014:358).

In order to provide reliable insight on the perceptions and practices of Caribbean and African eldercare workers in Greater Boston, I interviewed fifty direct-care workers. Of the fifty participants interviewed, thirty were from Haiti (reflecting the large Haitian community in Boston); four hailed from the Dominican Republic; four were from Jamaica; three migrated from Cameroon; five were from the Caribbean islands; and eight were from Africa.

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While the absolute numbers are less than immigrant healthcare workers from Mexico and the Philippines with 46,600 and 41,000 workers, respectively, black immigrant representation is important because of the concentration of ethnic immigrant flows into this particular sector of the economy. For example, eleven percent of all foreign-born Jamaicans working in the United States fill occupations within the “nursing aides, orderlies, and attendants” sector, as opposed to only 0.9% of Mexicans working in the United States labor force (Bloch et al. 2009). (This figure is 13.6% for Haitian migrants and 8.0% for Nigerian migrants.)
two were from Ghana; two were immigrants from Honduras; two were from Kenya; two migrated from Nigeria; and one participant was from Somalia. In order to draw comparisons between work contexts, I recruited twenty-six of the fifty participants from a home care agency in Greater Boston which specializes in providing home health, personal care, and housekeeping to local senior citizens. The other twenty-four interviews were with workers from facilities such as assisted living, continuing care retirement communities, and nursing homes in the Greater Boston area. The average age of the participants in the study was forty-eight years old – slightly older than the average age of forty-two years old reported in national direct care statistics. While women comprise eighty-nine percent of the direct-care work force (PHInational.org 2011), I intentionally recruited an over-representative population of male caregivers (n=10) to draw out issues of gender in carework and its intersection with transnational identity formation and family caregiving practices. While I attempted to recruit males and females that have responsibility for at least one aging family member abroad, I did not restrict my sample of caregivers to only those with overseas elderly relatives, since the perceptions of caring and the care systems of the sending country, and the practice of caring in the U.S. are still important to my study. More details about the sample can be found in the Appendix.
At the outset of my study, I intended to limit my recruitment to foreign-born eldercare workers who currently work in the low-skilled direct-care workers category of the U.S. Bureau of Labor Statistics. These direct-care workers include Nursing Assistants (CNAs) or Nurses’ Aides in facilities who help clients with activities of daily living (ADLs) such as bathing, toileting, dressing, and eating and in certain states, light clinical tasks such as blood pressure monitoring and range-of-motion exercises; Home Health Aides (HHAs) which perform similar services of care as CNAs but in home or community based settings; and Personal and Home Care Aides who tend to work in private or group homes and provide help with ADLs often in addition to housekeeping, meal preparation and medication management (PHInational.org 2011). As discussed below, challenges of recruitment within facilities produced a sample where one Haitian-born woman was working as a Licensed Practical Nurse (LPN) and two of the fifty participants were African immigrants working at the Registered Nurse (RN) level. Each of these participants had years of experience working as CNAs prior to their current roles. Another male participant was currently unemployed with past CNA, nursing, and program director experience, and three CNAs worked in facilities devoted to skilled nursing primarily for pediatrics. Most of the participants also had experience working in
both home and institutional settings through working multiple jobs or having their clinical training for the HHA certification take place in a nursing home setting. Initially, I viewed this diversity of the workforce in the sample as problematic, but during analysis I found the outlier cases to be informative and build on the rich findings and themes that resonated throughout the interviews of inter-staff tensions and comparisons of working with elders versus younger populations.

RECRUITMENT AND DATA COLLECTION

When I embarked on recruitment, I felt confident that I would be able to find many participants meeting the criteria outlined on my IRB-approved consent form:

Adult, first-generation immigrant from the Caribbean or Africa, currently living in the Greater Boston area, and working as a caregiver for the elderly either through home care services or at a nursing home. You may or may not be currently responsible for or taking part in planning for the care of an aging relative in the country from which you emigrated.

Being the family member of an executive director at a local elder services agency had practical benefits for my research – I was armed with an arsenal of potential contacts at the administrative level of home care agencies and eldercare institutions. Specifically, I had access to phone and email information for administrators of skilled nursing facilities and assisted living communities,
directors of home health aide trade associations of Massachusetts, owners of home health care and homemaker companies, and academics in the field of aging, and I had a familiar name to drop to get in the door. I hoped these contacts would help provide me access to the employees at their institutions and within their associations to recruit for my study.

Such connections proved fruitful at the outset of my research. The first twenty-four interviews lasting one hour each, on average, took place in three short months between January and March of 2013 at a local home care agency. After sending an email to Sue, the Vice President of the agency, explaining my research and requesting to have access to recruit home care workers at her agency, we planned (via telephone) that I would present my call for participants at a monthly in-service meeting. Sue and I met with Vera, the Service Coordinator of the agency’s Boston branch, two hours before the in-service to discuss my research and recruitment presentation. At the in-service, I explained my interest in interviewing first generation immigrants working as caregivers for the elderly about their work in the United States, and also any role they may have in managing care for family members in the country from which they
migrated. Although my original research plan was to restrict recruitment to Afro-Caribbean and African immigrants, I opened the call for recruitment to all first generation immigrants, regardless of race. Despite the expanded requirements, almost all of the participants (and those who did not participate due to their native born status) were phenotypically black – reflective of the nature of the racialized niche. Eight participants signed up to participate at the in-service. Vera offered to organize times that would fit with their work schedules after the meeting. An invaluable gatekeeper to the home care and home health aides, Vera also assisted with further recruitment in her daily conversations with the aides. Having a connection to a person that the aides

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7 When some of my language was met with blank stares, Sue and Vera interjected to offer broader questions to jump start a general discussion, e.g. “who here has family members in another country?” Fortunately, this helped to articulate the foundation of my research over the clumsy buzzwords (globalization) that I scattered throughout my presentation.

8 My status as a white, middle-class female graduate student contributed to a slight discomfort in having to give an oral presentation to a mixed group of foreign-born and native born home care workers where I actively singled out a particular cohort for my research. Sue and Vera already agreed prior to my presentation that I should expand my call to all foreign born participants rather than African and Afro-Caribbean immigrant, alone, but even with such an expansion the atmosphere was slightly tense when a few African American workers spoke up and expressed that they would have participated but they failed to meet the criteria – even if they had parents who were migrants. These feelings were compounded by the fact that I was already slightly uncomfortable justifying (real or imagined) why I, as a white American, would be interested in the isolated experience of black immigrants. Despite my years of research and publication on race and immigration and my unwavering belief in the importance of the work that these caregivers practice, my perceived outsider status made me feel very vulnerable to criticism. I reflected on this experience in several memos and field notes, vowing to change the format of recruitment of the second segment of institutional interviews whereby I would try to present my call for recruitment to the foreign born population directly rather than in mixed status settings.
trusted, along with a participation gift of a twenty dollar gift card to Stop & Shop, and an offer that the interviews would count for one hour of future in-service likely encouraged more participation.⁹

Vera notified me of scheduled interview times several days before interviews were to take place. She planned hour-long interviews around the aides’ schedules, which led to some days containing six interviews and other days with just one or two. Interviews generally occurred on Tuesdays, Wednesdays, and Thursdays, and all were conducted in a private office at the agency. All twenty-four participants showed up at their scheduled times, and so did the two additional male HHA participants whose interviews I conducted at the end of my data collection. Before each interview, I obtained documented consent from each participant and gave them the gift card. When I sensed some of the participants struggling with language barriers (particularly the Haitian

⁹ A generous grant of $1000.00 from the Boston University Morris Fund allowed me to compensate my participants for their time. Because eldercare positions pay low hourly wages, most people working in these types of jobs often have to take on a second job to make ends meet. Compensation was offered to help provide an incentive to participate in my research for these workers who face immense pressure on their time due to work and family obligations. Also, since many of my participants were engaged in sending remittances to their aging family members, a small compensation may have contributed to the broader impact of the study. Mary Waters (1999) found that payment for participation is the best way to ensure cooperation among the widest range of respondents, in order to avoid only recruiting participants who may carry specific agendas. Believing in the value of my research, Sue and Vera generously offered to allow the interview to count as an in-service hour for the workers, despite my initial plans to conduct all interviews off work-time.
cohort), I offered to talk through the entire consent form. All of the participants agreed to be audiotaped. I took notes on separate interview guides throughout each interview.

Accessing participants working in nursing homes and similar eldercare facilities proved to be a significantly more difficult task. During the week of April 15, 2013, I reached out to an administrator contact at a nursing home in the Greater Boston area to begin the process of recruiting nursing assistants. While the administrator agreed to put up my flyer, she did not want my presence on the facility’s campus. Sharon, an East African nurse (RN) from that facility contacted me upon seeing my posted flyer, however, and participated in an interview at her home. The interview lasted almost two hours with a few humorous interjections by Sharon’s children running joyfully around the house and asking their mother for homework help. The youngest child seemed fascinated at the appearance of a stranger asking her mother all sorts of questions and was perfectly content to sit nearby and listen until her mother urged her to go downstairs and play with her brother. Compared to my previous interviews at the agency office, it was refreshing to conduct the interview in a place comfortable for the participant, without the suggested one hour schedule of time
looming in the background. And while I was concerned that my first institutional interview was with a nurse rather than an aide, I was grateful to have a varied perspective and took comfort in the fact that Sharon had CNA experience in the past and could elaborate on the differences and similarities between roles. Also, Sharon insisted that I would easily find more participants and that she could contact a few friends who also worked in local nursing homes. I desperately hoped such snowball sampling would be successful, but as I learned over the next year, it was usually only when I was physically present to issue my call for recruitment that any interest and interview scheduling would take place.

Shortly thereafter, I contacted the president of a trade association for local not-for-profit nursing homes to potentially gain access to other nursing homes and nursing assistants. I was allowed to give an oral presentation at a meeting of administrators where I explained my research and my recruitment call. I also distributed my flyer and business cards. Several administrators agreed to post my flyer at their institutions, but again recruitment was only successful when I was able to personally connect with the CNAs or the directors of nursing who

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10 Throughout recruitment, I encouraged participants to choose a meeting place that would be convenient and comfortable for them. Since most of the interviews ended up being conducted on work time at the suggestion of the administrators, this led most meetings to take place in private areas at their places of work.
would introduce me to the CNAs. For example, the administrator of the assisted living facility where the presentation/meeting was held graciously allowed me to walk around the building and explain my research to the CNAs directly. I was able to schedule interviews with three aides at that facility. Each interview was conducted on campus in a private office (normally used for banking). Another administrator (who was present at the meeting) invited me to visit his facility’s campus in a wealthy suburb west of Boston and introduced me to both the director of assisted living and the director of nursing at the skilled nursing facility (SNF). I was invited to give a presentation to a group of aides on the assisted living side of the facility (who met the foreign-born eligibility criteria); three of which participated. The nursing director of the SNF introduced me directly to people who fit the criteria. Through her, I was able to interview four participants. One of my participants was an activity director and the other was a LPN, but both have worked as CNAs prior to their current positions.

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11 The office had windows to the cafeteria so that we could be seen talking, but the door was closed for privacy. During one interview, a white nurse walked past a few times and glared in our direction and finally knocked on the door with exasperation. She chastised the participant and condescendingly asked when she would be back at work, not knowing that the director gave her the time off to participate. When we told her it was a scheduled interview the nurse appeared visibly embarrassed, apologized, and left. I had paused the tape recorder during this interaction for transcription purposes. Once the nurse left the participant proceeded to tell me with anger that that’s how the nurses treat the nurses’ aides, “with no respect.” It was my first experience with the tense staff/race relations between the staff at institutions that will be explored in-depth in Chapter Six.
Throughout the fall, I actively contacted facilities and tried to garner participation. While countless institutions agreed to distribute my flyer or post it, the flyers failed to gather interest. My next move was an attempt to recruit through the local healthcare workers’ union. A colleague of mine at Boston University provided me with contact information of a Service Employees International Union (SEIU) administrator who in turn connected me with a nursing home organizer, who had also served as a CNA prior to full time organizing. I interviewed him in his office at the union headquarters. He provided me with a phone number of another Haitian male who agreed to participate. As I was about to interview Stanley at his home, his partner Darline (also a CNA) expressed interest in participating. I conducted one interview with both of them spanning over two hours. Like Sharon, Darline and Stanley’s interview incorporated a few background jokes and several helpful Haitian Creole to English translations from their adolescent son who was playing a video game and occasionally listening in the corner of the room. They also provided me with two phone numbers to contact, both of which failed to produce participants.

In addition to the union and the facilities, I reached out to ethnic organizations in Greater Boston and immigrant advocacy groups. Of the many I
emailed, I was able to connect with an employee at an immigrant resource center north of Boston, who spoke with two Haitian CNAs that were participating in their language program. We scheduled a time to meet but both participants cancelled an hour before the interview without explanation. I also had phone contact back and forth with the president of a local West African association. While he agreed to send an email out to their members, it did not yield any responses.

I utilized a contact at a Boston-area immigrant advocacy center, who sent an email to their member organizations on my behalf. Responding to this, the executive director of the Association of Haitian Women called me and invited me to announce my call for recruitment on a public access radio station during the Haiti Focus program airing Sunday mornings. Due to technical difficulties, she ended up making the announcement in Haitian Creole over the air listing my name, contact information, and (from what I could discern) a description about the study.

Through another colleague of mine at Boston University, I was able to connect with Erin, the director of an eldercare association and foundation that funds research on compassionate care and provides scholarships to CNAs working in eldercare to pursue further education. She granted me access to the
applications of eight scholarship winners (all immigrants from Caribbean or African countries). She then contacted the winners directly and encouraged them to participate. Two agreed: one male from Kenya (interview conducted at a local bookstore) and one female from Ghana (interview conducted at her home). Another scholarship winner expressed interest, but after two emails reaching out to schedule a time, never responded.

In April, Erin invited me to present at a meeting at the association where Human Resources (HR) directors and administrators of local nursing homes would be in attendance. I gave a short oral presentation and distributed my flyer and a sign-up sheet. Five HR directors provided me with their contact information, one provided me her business card, and several others agreed to post my flyer. I contacted each of the six the following day. I was able to meet with two participants at a nursing home in a suburb north of Boston (in a private library at the facility) in one-on-one interviews.

Through these connections facilitated by Erin, I conducted an interview with a Ghanaian man who, although currently unemployed and pursuing higher education, had experience in both CNA and upper level nursing and had also established several African community associations. Another HR director allowed me to conduct three interviews in the private hair salon of his nursing
and rehabilitation center. I gave another presentation to a group of CNAs in April 2014 at an institution in a suburb west of Boston, and got the names and numbers of four more CNAs who said they would be willing to hear more about the study and potentially participate. None of those contacts panned out. Finally, the director of a pediatric care facility and a close friend of Erin invited me to interview three interested West African participants separately at her facility. While the final three interviews departed somewhat from my original search criteria, the three participants were all CNAs and at least one of the participants worked concurrently at a nearby nursing home. My decision to conduct the interviews was also justified by the fact that nursing homes and skilled nursing facilities at times house members of all ages who need intensive long term care. I was also curious to discover any comparisons between caring for the young and caring for the aged in both the U.S. and in the sending countries.

DATA ANALYSIS

I used a Sony recorder to tape-record each interview (with the informed consent and permission of the participants). To ensure against breaches of confidentiality, I assigned each participant a code (e.g. Subject 1A, 2B, etc.) in place of using his or her real name on the interview guide and audibly at the
outset of each interview. These codes have been transformed into ethnically
equivalent pseudonyms and all locations and names mentioned in the interviews
have also been disguised. The interviews’ audio files were uploaded under these
code names to my personal computer that is password protected. I keep the
interview guides and notes in a locked file cabinet in my home residence.

All fifty interviews were transcribed into Microsoft Word. I attempted to
transcribe each interview in verbatim immediately after the interview but time
constraints occasionally called for bulk interviews to be sent to a transcription
service that requires transcriptionists to sign confidentiality agreements. After
reading through each entire transcript once, I began the process of coding for
concepts. Since I began data analysis for the initial interviews in the midst of
conducting other interviews I was able to review and add to my interview
questions throughout the process (Corbin and Strauss 2008).

The QSR NVivo 10 software was used to facilitate organization and
coding. For each interview, I began with open coding whereby I located themes
and concepts and organized them into nodes on the software. I also looked for
relationships between concepts and created descendent nodes or subtypes for

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12 I was able to afford transcription services through a grant from the Boston University
Department of Sociology Morris Fund.
differences within the overarching themes. For example, I created an overarching node of transnational care practices and then a descendant node I labeled “remittances.” When I found that remittances varied beyond money and included elder-care specific remittances such as wheelchairs and walkers, I created further subtypes. Although I used grounded theory and created new concepts emerging from the participants’ responses, I also utilized the literature on care work and actively coded for practices similar to those found in Diamond (1992), Foner’s (1994) and Stacey’s (2011) studies. This involved operationalizing emotional labor as work that exceeds physical ADLs by also including performing compassionate care, companionship, and “feeling work” toward elders beyond what may be included in the job description.

Throughout analysis, I often created analytic memos about different nodes and when I noticed patterns across the interviews. With axial coding, I noted whether factors such as country of origin, context of work (home or institutional care), or gender impacted the perspectives and practices of eldercare, in order to determine conditions and interactions of codes. Thus, to paint a comprehensive portrait of the eldercare system and the possible differences these settings may have on perceptions and practices, I compared and contrasted the type of care setting – nursing home or in-home care. In examining the impact of gender, I
looked at whether being male or female affects perceptions and practices in
caring for elders in both the paid U.S. care workforce or toward parents overseas.
I also explored how type of care setting and gender interact to affect the perceptions
of care (in the U.S. and in the sending country) and practices of care. For example, I
looked for differences and themes in the practices of worker identity
formation/maintenance between male and female caregivers across home and
institutional settings. Although my sample was unbalanced in regards to the
country of origin counts with Haitian immigrants composing over half the
sample, I still conducted analyses to explore any connections between country of
origin and factors such as retirement decisions (stay in the U.S. versus return)
and practices of care provided to aging relatives in the countries of origin.

STUDY LIMITATIONS

The greatest limitation of this research existed in the difficulty of
recruiting participants from the top-down (contacting administrators and
directors of nursing in order to access aides). If I had a strong network of direct-
care workers within which I could snowball sample, I may have been able to
conduct my research in a more timely manner and to prevent certain situations
where I felt the nature of conducting the research on work-time in an office or
room in the facilities or agencies contributed to the idea that I was essentially
“working for the boss.” I ended up facing a problem similar to Clare L. Stacey’s experience where it was difficult for her to develop “rapport with the home care aides during training and interviews as some suspected [her] of being a social worker and therefore a county employee ‘spying’ on them” (2011: 175).

Although I introduced myself as an independent researcher interested in their experience and the ways eldercare is practiced in their home country, potential language barriers and a general aura of mistrust between aides and administrators made it difficult to distance myself from senior staff. Not only was it problematic to recruit participants because of this, I occasionally had a sense that the participants could be portraying the institution or agency in a better light than deserved for fear of a breach of confidentiality.13

Alternatively, if the participants are not merely “covering up dissatisfaction” by distancing and projecting critique on other institutions, perhaps the places that agreed to let me conduct interviews are systematically and measurably better care facilities than the average home care agency or nursing home community. Also, those facilities where participants were

13 In fact, I found that participants often used a method of distancing when discussing the critiques of carework or the institutions where such care takes place. When asked about their dislikes and difficulties in work, most participants articulated that other places in which they have worked, heard about, or seen briefly during clinical work were the true culprits of poor management and working conditions.
recommended to me under the guise of “fitting my criteria” by senior staff may also be participants more likely to have satisfactory opinions about their place of work than disgruntled workers not presented as possible respondents. Indeed, the most noticeably outspoken critics of institutions were those participants who I reached through union connections.

As a white, middle-class, young adult woman from Boston, MA, I am aware that my status potentially had an impact on the interviews and my perspective on the situation as I’m not located in the same ethnic, racial, or socioeconomic standpoint as the participants in my study. In order to understand the broader picture of the participants’ lives and experiences of migration, I opened each interview with general life history questions to better see how their perceptions and practices have been shaped over time. Because I have also worked with elderly populations in summer jobs such as serving meals at senior meal sites, delivering Meals-on-Wheels, and administering surveys to check on the safety and services awareness of elders ages 85 and above in suburbs around Boston, I constantly practiced self-reflection to check for and remove any value judgments I have towards different types of eldercare (nursing homes versus home care) and make sure that the interview questions were free from assumptions. Stories like James’s are important, and I made every effort to
present his and the following stories in a way to preserve the meanings that the participants intended to portray, using their own words to indicate their constructions of knowledge, and convey their personal experiences.
CHAPTER THREE: Comparing Care: Perceptions of Eldercare Systems from a Transnational Optic

Sahra: No, perhaps if they make nursing homes [in Somalia], it would be nice. Because many people don’t have families and even if many people have families, the people are not the same [as before]. In my culture, you have to take care of your parents, grandparents, or elders; you’re expected to take care of the family. That is in my religion and in my culture. But, the people are not the same. Some people they don’t care –
Megan: In Somalia now?
Sahra: Yeah! Some people, many people, they don’t care. Some people go looking for a life. They go looking for a job. They pay for everything and many people, they don’t have the time to take care of the parents. So what I see now in that situation, and what I see here in America – because I didn’t see that in other countries – I see that home care is good for some people because some people don’t have people to take care.

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Sahra’s perception of the changing “culture” of Somalia and the utility of formal care in time-pressed economies elucidates the dynamic nature of globalization and the role it plays in migrant lives and the management of care for families around the world. Contrasting the idealized construction of her past life and the old values of her homeland with her experiences in care work in the United States and what she imagines as a cultural shift in Somalia, Sahra interprets home care to be a feasible answer to growing elder abandonment. To

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14 While Sahra attributes cultural changes and elder neglect to commodification in this passage,
her and the rest of the caregivers interviewed, a changing world calls for innovative solutions to preserve the sense of familial comfort and dignity for elders. Determining exactly what those solutions entail requires a streamlined concept of compassionate eldercare and an evaluation of the ways in which countries, institutions, and families achieve or fail to provide it for aging populations around the globe.

By working in the field of direct care that transcends the boundaries of distinct public and domestic spheres, these immigrant caregivers have ample opportunity to incorporate elements of their family histories into their work and their work experiences into what they remit back to their families and communities. The exposure of different systems and styles of care allows participants the ability to evaluate strengths and weaknesses of each system in relation to the other. These immigrant caregivers derive a sense of agency from locating weaknesses within the care systems and realizing their unique caregiving roles as means to fill these voids.

elsewhere she notes the detrimental impact Somalia’s civil war had on families, including her own. Sahra, the only asylee in the study, traveled a strenuous path through several countries before reaching the United States, leaving her husband, father, and several other family members behind. With her six children in tow, she finally reunited with her mother and sister who had escaped as refugees prior to her departure. Despite these perceived cultural changes in Somalia, Sahra wants to return upon her retirement and grow old in her homeland. She perceives that there remains a fundamental difference in culture and the time available to spend with loved ones in the United States versus Somalia and expects that she will always “have family around” should she return to her country of origin.
This chapter details these caregivers’ perceptions concerning the relationship between the political economy and provision of eldercare, the availability of and access to medical technologies for seniors in each country, and general observed familial roles and responsibilities in providing care. I find that through analogous comparison of the strengths and weaknesses of care systems, these caregivers produce a general definition of compassionate eldercare as the delivery of life saving medical care and skillful emotion work that ensure the elder feels dignity in body and mind. They recognize limits on caregiving imposed by income inequality and weak welfare regimes that produce atmospheres of resource deficit and emotional deficit in the countries of origin and country of settlement, respectively. Their perceptions provoke these caregivers to attend to the observed deficit and provide well-balanced care for their dependents, whether family or fictive kin, in ways that will be discussed further in the chapters that follow. Put simply, these caregivers consider both love and money as essential ingredients in bestowing quality care.

*Constructing Care Responsibilities*

By evaluating the state of care, determining the level of need for their family members and clients, and ascertaining how they best can fulfill that need, these caregivers convey the broad definition of care offered by political scientist
Joan Tronto in her work, “An Ethic of Care.” Tronto and her colleague, Berenice Fisher, define care as “a species activity that includes everything we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web” (Fisher and Tronto 1990:40 as cited in Tronto 1998). The authors distinguish four phases of care – Caring about; Caring for; Caregiving; and Care-receiving – that correspond to the moral imperatives of attentiveness, responsibility, competence, and responsiveness. Tronto (1998) elaborates:

“Caring about” involves becoming aware of and paying attention to the need for caring. Genuinely to care about someone, some people, or something requires listening to articulated needs, recognizing unspoken needs, distinguishing among and deciding which needs to care about. “Caring For” is the phase in caring when someone assumes responsibility to meet a need that has been identified. Simply seeing a need for care is not enough to make care happen; someone has to assume the responsibility for organizing, marshaling resources or personnel, and paying for the care work that will meet the identified needs. “Caregiving” phase is the actual material meeting of the caring need. Caregiving requires that individuals and organizations perform the necessary caring tasks. It involves knowledge about how to care. “Care receiving” involves the response of the thing, person, or group that received the caregiving. Whether the needs have been met or not, whether the caregiving was successful or not, there will be some response to the care that has been given. (Pp. 16–17)

Tronto and Fisher included phases of care in their definition to offer a more nuanced picture of an ideal process of care that encompasses both feeling and
activity (Glenn 2010). Too often care is understood as either mere physical work or overly reliant on the emotional aspects of care. According to Tronto, the caring process involves a complicated series of moral, political, technical, and psychological judgements. Tronto explains that caring “is neither simple nor banal; it requires know-how and judgment, and to make such judgments as well as possible becomes the moral task of engaging in care” (1998:17). Building on Tronto’s theories, Peter Moss argues that an ethics of care “posits the image of a relational self” with the caregiver “interpreting responsibilities to others” and then making “situated decisions” (2014:423).

For the black immigrant caregivers in this study, situated decisions concerning care responsibilities reflect their transnational social location. Their immersion into an eldercare niche in the United States fosters new ways of thinking that recognize and adapt to a need for advanced health care tailored to elderly populations in the countries of origin. Similarly, working in this field provokes fond recollections (both real and imagined) of frequent togetherness, solidarity, and interdependence that they believe could enhance the lives of “lonely” senior citizens in the United States. When evaluating care systems, then, these immigrants’ conceptions of ideal care provision are shaped by the resources available in the country of origin and the sending country. Levitt and
her coauthors (2015) use the term “resource environment” to account for the complex social protections transnational migrants piece together to provide for themselves and their families. They argue that state supports, markets, third sector (e.g. non-governmental organizations) and individual ties are forms of protection available to immigrants to varying degrees determined by their citizenship or resident status in the receiving country and the mobility of social supports in their sending countries. Thus the “situation” created by institutional settings, care cultures, and state policies that make up each country’s care regime shape transnational care perceptions for these immigrant caregivers (Díaz Gorfinkiel and Escrivá 2012).

Although these caregivers establish transnational ways of being and belonging (Levitt and Glick Schiller 2004), policies forged within national and state boundaries continue to influence their perceptions and behaviors. Kilkey and Merla (2014) explain:

As Ryan (2011:87) argues, ‘migrants may not be entirely bounded by the local but neither are they entirely free and unfettered within transnational spaces.’ It is important, therefore, to acknowledge that the institutional contexts in which [Transnational Family] care arrangements are configured are constituted in different levels and sites of governance. These include the global, regional, sub-national and national. Moreover, those spaces are not separate and mutually exclusive entities, but interconnect in a range of ways (Clarke 2005). (P. 218)

Because they are situated in a transnational field, then, these caregivers develop
at least two points of reference that guide their determination of the need for care and how they can contribute to fulfilling their responsibilities as caregivers. At the national level, each country has its own set of policies as well as a culture of care, or the “norms and structures that shape the organizing of care societally” that dictate the current state of care (Zechner 2008:41). In other words, “care cultures incorporate norms on appropriate forms of care (for example, familial versus non-familial) (Williams and Gavanas 2008) and influence the characteristics of the care regime in any country, as well as the arrangements deemed appropriate for different groups in the country” (Kilkey and Merla 2014:217). Table 1 offers a typology of the overarching perceptions caregivers formed about the “care regime” of the United States in relation to the countries of origin.

Table 1: Perceptions of Care Systems

<table>
<thead>
<tr>
<th>Country of Settlement (USA)</th>
<th>Country of Origin</th>
<th>WHO IS RESPONSIBLE FOR COSTS OF ELDERCARE?</th>
<th>WHERE DOES ELDERCARE PRIMARILY TAKE PLACE?</th>
<th>WHAT TYPE OF ELDERCARE IS VALUED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government (Federal &amp; State)</td>
<td>Family</td>
<td>Facilities and/or Home with Formal (Paid) Assistance</td>
<td>Home Except for Medical Emergencies</td>
<td>Skilled Physical Care at the Expense of Emotional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Emotional Care at the Expense of Skilled Physical Care</td>
</tr>
</tbody>
</table>
Broadly, these immigrant caregivers perceive the United States government as responsible for ensuring care for its dependent citizens. They believe care takes place primarily by paid caregivers (in the home or in facilities) where the focus is largely on preserving physical health through the implementation of strict standards and tight schedules. Although many caregivers identify American culture as inherently materialistic and individualistic in comparison with the cultures of their homelands, they often acknowledge that while the state takes responsibility for its aging population, younger generations that could feasibly serve as familial caregivers are barred from doing so due to the pressure to work and a lack of time to devote to care. Thus, the care situation is a consequence of neoliberalism in both mind (culture) and matter (time).

Alternatively, these caregivers view family as responsible to provide eldercare for aging relatives. Unless the elderly family member faces a medical emergency, upon which he or she would be transported to the local hospital, family members, a friendly neighbor, or perhaps a member of the local church are tasked with providing care within the home. Because physical care such as medical care and assistance with ADLs requires income to pay for services, and because these family members are often untrained in geriatric health, these caregivers focus on the benefits of emotional care perceived to be abundant in
the countries of origin. While these caregivers often identify interdependence as a cultural feature distinct from the individualism of the United States, they also recognize that such interdependence can be a consequence of the lack of jobs available to individuals of working age, opening the door for greater time to devote to caregiving.

It is important to note that these judgments and evaluations of care regimes stem from caregivers’ awareness of a combination of actual policies along with an imagined state of care. For example, some caregivers speculated that nursing homes had yet to be built in their country of origin, while others from the same country were aware of nursing institutions provided by their local church. Given the qualitative nature of this study, the focus rests on “meaning making” and how these immigrants understand and confront global structures of inequality to determine caring responsibilities (Espiritu 2003). Although perceptions of home and broader state structures might be idealized notions and these caregivers may not be aware of new or changing structures that might offer an alternate path to care, the beliefs they espouse have very real consequences for constructing actual care behavior.
EVALUATING THE U.S. CARE SYSTEM: A STRONG STATE\textsuperscript{15} WITH WEAK RELATIONSHIPS

\textit{The Deserving Elderly}

These caregivers learned about the United States welfare regime through their occupation and their own migration experiences. In the United States, and particularly in Massachusetts, housing and healthcare for elderly are largely subsidized through means-tested measures coupled with Social Security. These immigrant caregivers gain understanding of the nature of U.S. social entitlements “to benefits and services in areas related to health, income, housing, and education” through the lens of a low-income worker (Kilkey and Merla 2014:217). They learned that such entitlements or lack thereof, influence their time and finances, shaping how they care for their families and how they plan to spend their retirement.

Although the “bootstrap” narrative of the American Dream was widely known to the caregivers prior to their migration journeys due in no small part to the propagation of American Exceptionalism ideology across the globe, many of these immigrants were surprised at the level of government assistance available

\textsuperscript{15}I use the term state interchangeably with nation-state to indicate perceptions regarding federal or country-level political processes (Dean and Ritzer 2012).
to certain segments of the population (Kibria et al. 2014). Edouard, a male home health aide from Haiti who recently migrated to the United States with his family on Temporary Protected Status, recalls his surprise in seeing how social welfare and the accessible provision of healthcare and eldercare is readily available for people in need:

Megan: When you said that it is different in the U.S. versus Haiti, what did you mean?
Edouard: In terms of taking care of elderly. In Haiti, they don’t take care of elderly people like in the United States. It’s not the same thing. I never knew that the government could take care of elderly people like that. When I came to the U.S., I saw how they really take care of elderly people. I think it is really a good thing, because the elder people can’t take care of themselves. They need someone to help. I think it’s a good thing. In my country, they don’t take care of elderly people, but here it is different for children and elderly people. It is not the same in my country.

Despite his initial surprise that the government provided such far-reaching benefits for his home care clients, Edouard applauded the system and viewed it as a way for individuals to maintain a positive quality of life despite their inability to work. Rather than regarding dependence on the state as mutually exclusive to the narrative of independence, many of the caregivers viewed the elderly as “deserving of care.” They felt senior citizens earned the right to be cared for after a long life of work. Tina, a homemaker and HHA from the Dominican Republic explains:
I love my country, but the system is terrible. They don’t help the people when the people are old and sick. But it’s that way almost all around the world. The system is going to change when Jehovah take control of the system, but now everything is terrible. (Tina laughs) A lot of it is unfair, but for now, in the United States, we have something good. They take care of the people when the people are old or sick. For me, it’s smart. It’s the most fair in the world when you spend all your life working and when you’re older and [experience] the hard part, they are there for you.

Tina likens Social Security to an idea of reciprocity that reflects the same obligation and attachment children often feel towards the parents that raised them. Felix, a home care worker and CNA from St. Kitts elaborates, “The elderly put the country on top because when they were young, they worked and built the country to be what it is. When their time is done, the country is supposed to be there to assist them in any cause because, as I say, they build the country.

Where would this country be without the elderly?” In one rare instance, Farah, a HHA and CNA who arrived to Boston almost five years ago under Temporary Protected Status after the devastating earthquake in Haiti, bemoans government assistance for able-bodied younger generations.

Farah: In America, they do everything. They pay for home care. They pay for nursing home. They give us food stamps. They do medical care for the seniors. Oh, this country! (Farah laughs) You can’t have a good economy because it’s too much by the government! I think it’s too much, yes, I think too much! When you look at the nursing home, almost all of the residents have Medicaid; government, government, government! Oh! Some in home care get food stamps and Medicaid. They get medicine. All the things! It’s good, it’s a great thing but I think it’s too much. Sometimes I think in this country, the people, some of the
people are very lazy, because she files for everything! She files for food stamps and sometimes she can go to work. She refuses to go to work just to take this advantage. Sometimes, I see somebody who says, “I can’t go to work because if I go to work, they’re going to ask me to pay half of my house.” It doesn’t make sense. For the elderly, that’s okay; it’s too much for the young people. If you have the potential to go to school or to work, I’m going to cut you off – your food stamp, I’m going to cut your SSI and I’m going to maybe pay for school for you but after, you go to work! You can! For the elderly, that’s okay, but for the young people - very nice, but you can go to work!

Farah thought the provision of social welfare was excessive and that help should be restricted to aging populations alone to discourage “laziness.” This sentiment was rare among the participants, however, likely due to the nature of the field they work in that lives below the poverty level. Several of the caregivers need government assistance, or plan to use it in the future, in order to make ends meet.

Therefore, the caregivers in this study felt that the United States government is particularly generous to elders and other vulnerable populations. They believed the state appropriately rewards elders who have devoted their lives to work. Positing the notion of “the deserving elderly,” these caregivers praise the government’s commitment to its senior citizens and the way such benefits make strides in leveling the playing field so that all elderly, regardless of economic or social capital, could have somewhere and someone to care for them.

Nadine, a HHA from Cameroon, explains:
I think the U.S. is really concerned about the wellbeing of the elderly. You know, it’s a top priority. That portion of the population matters to the U.S. You know like, the services that we are giving them for instance, it’s like they almost deserve it. They qualify for it, just because they are senior or because they have some health problems. They have somebody who works for them, the case managers, somebody, the family they go to help them. All those structures, they exist, you know, for them. You know they have a place where to turn for help, for whatever. And I really appreciate that. So there’s no elderly that can be stranded, you know. If you didn’t do anything, you don’t end up in the streets. You are able to finally be taken care of.

The theme that the state provides a safety net for senior citizens who might otherwise be abandoned resonated with many of the caregivers. Implicit in this idea is the belief that those senior citizens without familial care are the most at risk when it comes to housing and medical care. She also noted that sometimes the severity of the care requirement is too much for a family to handle, and in such cases, the existence of nursing homes (and the money to pay for them) are viable solutions:

Nadine: I just want to say that I think America is doing so much for the elderly. Even the nursing home is essential because the children of those people who are there bring them there when their parents couldn’t cope anymore on their own. So the nursing home was like a solution. Yes, America takes care of the elderly and it’s really appreciated. Because when you come here, you think you’re going to see racism, but you don’t see it in that domain. You know when you want to qualify you’re going to have service, they don’t care your color, your whatever. You know I’ve seen everybody - even some people that are not, that were not born here. But because they have become citizens they qualify, they have the service. They got it. That’s so beautiful! From Haiti, Dominican Republic, from Kenya! They have the services that Americans are having just because they are seniors. So that is a very big, a very giant step towards the wellbeing of the
elderly in general population.  
Megan: Was that a surprise to you?  
Nadine: Yes, I was surprised! I thought it would be only for Americans. You know but it’s for anybody who lives here and who qualifies.

Citing the inclusivity of welfare and social insurance programs to immigrants that work in the United States, Nadine believes the safety net of the government helps ensure the physical wellbeing of the elderly. Stephanie, a home health aide from Haiti echoed this sentiment, citing her own experience accessing means-tested benefits:

Stephanie: The government here [takes care of the elderly] like 100 percent. Yeah, they’re really good, they’re really, really good. They care for them, they take care of them. They respect them too.  
Megan: The government?  
Stephanie: Yeah! [They take care of] the child, the old people, the women. They give good care. I remember when I came here, I wasn’t working, and when I went to ask for help, they gave me food, MassHealth, they gave me cash, you know! It’s very good.  
Megan: Do you see anything the U.S. government could improve on?  
Stephanie: Yeah. You just need your papers. You need Social Security; your green card; proof of address.  
Megan: So do you mean it’s difficult unless you have papers?  
Stephanie: No it’s not difficult. If you are a single woman they support you, whether you have a paper or not. I remember I have one friend, she had a visa, and her mom had a visa, but she didn’t have the paper. But she was really sick, she was blind. And even though she didn’t have a paper they did everything for her. They gave her a home health aide to go to her house. The government is very good for them.  

Whether anecdotal or stemming from concrete experience, these caregivers believed that the U.S. government helped those in need by providing a pathway
(through insurance or subsidies) to receive healthcare. They were impressed by the appearance of equitable care provision (to deserving populations) that trumped a strictly market-based care system.

Many caregivers in this study contrasted what they perceive to be universal benefits for the elderly with familial-funded care in their country of origin that is largely dependent on socioeconomic class. James, a Registered Nurse at a Continuing Care Community, offers a comparison between his understanding of the U.S. system and that of Kenya:

You’ve got to give the government credit. People complain over here, but guess what, when you’re being taken care of, Medicare is covering for you if you’re skilled. If you can’t afford it, Medicaid is paying for your health. In Kenya, that’s a dream; it’s what you have. If you don’t have it, you don’t have it. In my country nowadays people have health insurances and all that but only a very small percentage; people pay bills out of pocket.

Megan: Only a small percentage of people have health insurance? James: Yes, those who can afford it. It’s not a basic need; that’s why you find most people die young because they can’t afford to go to the doctor. You’ve got to give the U.S. government or even our state a lot of credit. Me? I cannot complain. Just to go see a doctor and I just need to pay $15.00 as co-pay? Oh, I shut up and I pay it right there! Because I know if I was in my country and I was ill, I wouldn’t survive, I wouldn’t afford it. The seriousness of how people take care of other people over there is not as high as over here.

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16 Each of the facilities and the home care agency require documentation of legitimacy to work in the United States. To be sure, I did not ask immigrants about their citizenship status due to the sensitive nature of the subject. Questions surrounding the push-pull factors and early migration experiences occasionally revealed undocumented beginnings that have since been converted to legal residency. On the other hand, several immigrants proudly commented on their United States naturalization and how citizenship would facilitate the migration of future relatives.
As James illustrates, the transnational social position of immigrants allows them to evaluate government policies and services of each country simultaneously. Whether or not presently able to take advantage of social insurance entitlements or needs-based services in the U.S., many immigrants are aware such programs exist. These immigrant caregivers are constantly exposed to the usage of healthcare and social services by patients and clients and the advantages safety nets can have on improving the quality of life for elders.

While the overarching theme that the government “takes care of the elderly” prevailed through most of the interviews, several caregivers note that the safety net comes with limits based on class. They often draw on their varied experiences in several facilities to note the difference in eldercare provision for Medicaid-based payers and private payers:

Mirlande (Haiti; HHA; Assisted Living Facility): Like Medicaid. But like, let’s put it that way. I don’t want to call people’s names but I just want to do that as an example. Let’s say if the Obamas – let’s say if Michelle’s mother needs to be in an assisted living someday, she’s not going to have the same treatment as my mother because she’s rich. You see what I mean? So that’s the thing. They put everybody in levels because the government is not going to do anything because they are rich. They can afford everything, so she can get the better care. But my mom, she wasn’t here, and the government has to give her benefits because she’s an elderly person, they have it programmed for elderly, but it’s not going to be the same treatment.

While Mirlande appreciated the pathway to care offered by the government, her
occupation in direct care raised her awareness of “better care” for those that can pay for it. Claudia, a home health aide from the Dominican Republic, also recognizes the imperfections of the “system” noting the wealthy to be the true beneficiaries of a government that values capitalism:

[The United States is] a great country. They have good administration that you see if you come from a different place where there is corruption, I mean, everywhere there is corruption, but this country has better administration. Every person, the government has to meet the person’s needs, you know, through housing and maybe the government gives money for folks when they need it. It’s different, but it’s a great country. I feel good here. I don’t have complaints about the administration in this country. My complaints are about the feelings, but it’s happening around the world. The administration is good. Maybe it would be better, you know, maybe it would be better.

Megan: What do you think would make it better?
Claudia: You know, the executives, the higher-level executives for different companies have too much money and pay less money in taxes than a secretary, like Obama said. (Claudia laughs) It is not perfect. The system is not perfect. But you know, the people kind of feel that the government gives them a lot of help. My mother, my mother died, she had Alzheimer’s. My mother had everything in my house, everything. Everything my mother needed, we had. Good attention, good medical assistance – we had that. And my mother never worked here, never worked. You know, in my country, hoo hah ha, that can’t ever happen!

It should be noted that while the caregivers perceived Medicaid to be conditional to one’s socioeconomic class whereby the “poorest poor” or those without financial and social means for care receive the benefit, approximately 60 percent of nursing home residents are on Medicaid (Rodriquez 2014). This
disproportionately high number results from the common practice of the “spend down” (Diamond 1992; Rodriguez 2014). In his ethnographic work, *Making Gray Gold: Narratives of Nursing Home Care*, Diamond (1992) details the increasingly privatized healthcare industry throughout the end of the twentieth century:

Federal and state agencies set limits of time and category on what they can pay the corporations and physicians through the Medicare and Medicaid programs...Although the programs are said to be for older persons and the poor, a recipient does not receive benefits from either one directly. These public monies are transferred to corporations and physicians. The Medicare program puts a strict limit on the time care is paid for in a nursing home, after which residents or spouses, or both, have to exhaust their resources, the process called spend down. The Medicaid programs vary from state to state, but all, in effect insist on poverty as a criterion for eligibility...Public funds are such a large part of the income of these businesses that nursing homes constitute an industry subsidized by the state. As inspector, the state functions to endorse nursing homes as a private industry. It inspects for cleanliness and exact records with appropriate numbers, all the while validating and encouraging the process of pauperization for staff and residents. (Pp. 201–2)

Thus although the caregivers identify Medicaid as helping those who need it most, the system encourages elders to deplete or transfer their assets in order to qualify for the need-based benefit.

*The Perceived Cost of Benefits: Physical Work over Emotional Work*

To qualify for Medicaid reimbursements, institutions must achieve certain benchmarks and undergo frequent audits by state inspectors. Caregivers, particularly those who worked in facilities, felt that this reliance on the state
encouraged a greater focus on the physical tasks of care work, often rendering emotion work invisible and undervalued. Kwesi, a former CNA from Ghana believes a weakness of the U.S. eldercare system is this reliance on funding that overshadows the importance of building human connections: “They depend upon what kind of insurance you have to get the best care. Doctors are running on time. So they don’t seem to spend too much of their time on one patient. You could be fired if you do that. It’s like fast-paced here. You miss the human connections and stuff like that because we’re all running after money.” Fabiola, a home health aide from Haiti who has also worked in nursing homes, believes that nursing homes cut staff and overextend those who work there in order to make a profit. She feels that this structure of nursing homes reduces time available for each patient, deteriorating the quality of care and quality of life for the care recipient:

Fabiola: [If I had to give a suggestion to improve the system of care in the U.S.], for me it would be to make the nursing homes better. The government needs to make that better. They give you too many patients. You don’t have time for that. About the food – they give you this expired food. I don’t like that. You don’t have time to talk to the patients. I like to do that sometimes for the nursing home, but [the administration is] very strict. People work for money but they don’t have time for the patient. You end up doing something very quickly, very poorly for this thing. No, that’s not good.

Fabiola’s astute observation regarding the relationship between state benefit
distribution and the institutional values of care reflects a common problem throughout the United States (Diamond 1992; Rodriquez 2014). Rodriquez attributes this to the “fee-for-service” design of Medicaid and Medicare that conditions reimbursement money on the services provided by the nursing homes. He explains that “nursing home managers push for the documentation of daily care that makes Medicaid residents look incapable and dependent because it increases their reimbursements” (2014:21).

Although the U.S. federal government sets minimum standards, state governments set individual eligibility criteria (Medicaid.gov, N.d.). In other words, “oversight is principally federal, but each state administers its own Medicaid program and establishes its own eligibility standards, scope of services, and reimbursement rates to health services organizations” (Rodriquez 2014:21).

To be sure, several of the participants in this study acknowledged what they perceived as different “administration” in Massachusetts as opposed to other states. They often cited Massachusetts as being at the forefront of affordable healthcare. Samuel, a HHA from Haiti explains this distinction:

Megan: Do you have any other thoughts about eldercare in Haiti versus eldercare here?
Samuel: Okay elderly care in Massachusetts in comparison to other states, I’ve got to tell you, is different. In terms of elderly care, they are very good. Massachusetts, when it comes to the home care they have the best healthcare.
Megan: Best healthcare?
Samuel: Yes, so when it comes to the checking and the routine …that’s the type of healthcare even the country itself wants to give. I mean the whole country wants to imitate Massachusetts’ healthcare system. They are very good; they reinforce the routine checking. The insurance law plays a great role in that because they want to cut money and as far as you can prevent certain problems with routine checking, they will have less spending in the end to fix it. They are smart when it comes to the bureaucracy. When it comes to health management it is born here, the whole America is born in Massachusetts!

Samuel also praised Massachusetts for what he perceived as innovation and investigation. While these caregivers detected ineffective nursing home structures in Massachusetts, they often called attention to worse situations in other states with greater cuts in public expenditures.

Regardless of perceived strengths of the Massachusetts system compared to the rest of the nation, senior citizens in Massachusetts are embedded in the same federal program of Medicaid where reimbursement to nursing homes “is not allocated according to how much time it actually takes to provide care. Rather it is based on state estimates of how much time care should take” (Rodriquez 2014:24–5). By turning residents into the “personification of

17 Despite the informed consent form and my explanation that my research was not funded by the state but rather an academic pursuit, he likened his interview with me as something unique to the state of Massachusetts whereby the state invests in surveys that “communicate with people on the floor, what they need” that “will help the decision makers improve healthcare.” He claimed that most other states would think the study was a “waste of money” but that in Massachusetts “they invest in everything.”

18 Experiences in Florida were most often called upon to provide a comparison case to Massachusetts. Many of the Haitian immigrants in this study migrated to Miami prior to settling in Greater Boston. They found Massachusetts to have “better jobs” and “better healthcare.”
reimbursable activities that are neatly measured and quantified for the state”
these caregivers believe the receipt of benefits contingent upon “instrumental
and documented acts of care” comes at the expense of quality, emotion-infused
care (Rodriquez 2014:25). Chapter Five of this dissertation explores how these
institutional caregivers feel pressure to come up with unique ways to define and
practice emotion work under tight schedules and strict guidelines to fulfill their
goal of enhancing their residents’ wellbeing.

These fears of overshadowed emotion work were not limited to facilities,
although they were most often attributed to such institutional arenas. Judeline, a
HHA and CNA from Haiti, who I recruited to participate in this study through
her home care agency, recognizes the impact of budget cuts and reliance on
physical care as seeping into the quality of care provided in home settings:

Judeline (Haiti): The weakness [with the U.S. system] now I see is the way they
cut the budget. They have less hours, but some clients need more care. It’s
financial. Some need someone to sleep with them but they can’t afford that.
Megan: Overnight care?
Judeline: Yes. The weakness I don’t like about here is that they leave the elderly
by themselves in the house with Lifeline. No. My friend’s father, even with that,
he dropped dead. He didn’t even have the chance to press that or to grab the
phone. When we got into the house the way he died it was like he tried to reach
the phone and he missed it.

Although almost all of the caregivers praised the medical benefits of Lifeline™
(an emergency medical alert device), Judeline bemoans an indirect consequence:
the newfound reliance on automation at the expense of having personal
coverage. She believes that there are limits to providing quality medical care that
still require having a helpful presence to watch over the dependent.

“Back home people help, but here even your close friend won’t volunteer to help you.” –
Beverly (Jamaica; HHA, CNA)

Compounding the perception that “time” was hard to come by to devote
to the emotional aspects of care in both institutions and home settings was the
idea that senior citizens in the United States are isolated and lonely. Contrasting
the nature of the familial care in the U.S. (or lack thereof) to the communal
arrangements in the countries of origin, these caregivers often initially felt that
the perceived individualistic culture of the United States that emphasized work
rather than family values, created a deficit of “love” and contributed to the
“abandonment” of elders. Naomi, a CNA from Cameroon explains, “Most of
them, their problem is just … their weaknesses is just with the family because at
times they are happy but they just need their family love, but they don’t frequent
them. Some do though, but most of them, they are lonely.” Several of the
caregivers believed the American value system to be fundamentally different
from the communal and interdependent cultures of the countries of origin.

When asked about his entry into the healthcare field, Kwesi draws on this idea of
When you come over here, and the person who invited you works in the health field, it is more than likely that he or she will make a recommendation at the place where he or she works. That’s why mostly the immigrant population around here would find themselves doing healthcare, and that seems to be a stable job. I think, by nature, we are more nurturing. Where we come from, we tend to take care of each other. We don’t have a problem in that area because we are loving people. We have that trait.

Many participants used this cultural frame to both inform how they acted towards people and to influence their own retirement decisions. Allison recalls having to learn new “rules of the game” in the U.S. that were far different from the cultural norms that were instilled in her throughout her childhood in Jamaica:

[In Jamaica] they respect the elderly and they help in whatever way it can. Like the elderly, people go to their homes, “You need any help with this? I can do this, I can do that.” Like if you see them, people help them, you can help them. Like here, you see someone crossing the street, and they’re blind or something. Like sometimes, I wanted to help them but my friends and family are like, “Don’t do it, don’t touch them. They’ll sue you.” Sometimes, I forget I’m here, and not in Jamaica. Because [in Jamaica] even the neighbors like … Say for example, my grandparents, they’re home, sick, and my mom and I are … we have to go and run an errand. Oh we can just say to the neighbor, “Okay, you’ll just stay with her or look in on her to see how she’s doing?” They’re like, “Go. Fine, no problem” or stuff like that. But here, you can’t really do that.

Mirlande, a HHA in an Assisted Living Facility discusses a similar revelation in regards to her children and the dissolving tradition of filial piety upon migration:
You don’t expect anything from kids right now. Mostly this generation of kids, you don’t like hope that they are going to give anything back for you. They will focus on them. So I hope honestly to go back to Haiti. Go back to Haiti and stay with my family, uncles, nephews, aunts and have them take care of me instead of staying here or leaving me in a nursing home. Yeah...[Here], you cannot like focus on when you’re getting old; your kids cannot take care of you. All people here, they have kids. Where are they? You know, some of their kids live in California, in Florida, everywhere. They see them once in a while, once a year. You can’t count on kids.

Mirlande conflates the cultural frame of American individualism with the idea of a globalizing generational frame. She cites the abandonment of elders in the United States as evidence of a broader cultural shift towards individualism around the world. Similarly, Sahra reflects on the lack of familial support for her clients, and determines that she would ultimately like to return to Somalia in her old age. Although Sahra received political asylum from the U.S., her fond memories of communal spirit trump the isolation she perceives elders face in the U.S.:

I’d like to go back to my country. Because when you grow up, and when you are aging in your country, you know everybody. When you go back you have some people around to visit you. But here...back home the people live with them, but here, the life is hard. In America, the life is hard. You go in the morning to your job, and you leave your parents at home. When you come back, five o’clock, six o’clock, you never know what happened! Some people say to me, “Oh Sahra! Nobody came to visit me today! I didn’t see my grandson, I didn’t see my daughter!” I feel bad. And sometimes I feel sad and I say, “Oh when I grow and get to that age, I’m going to go back to Somalia.” Yeah, because the life is easy. It's not like here. The old people they’re walking around, they come to you, they
visit you. But America it’s you close the door, you left, and when you come back – you’re alone. So I’d like to go back to my country.

While Allison did not directly attribute her disappointment in American cultural values to a desire to return to Jamaica in the future unlike Mirlande and Sahra, all three participants felt that their presence could enhance the lives of their lonely American clients. Thus, participants often lamented the lack of communal values in the United States that they perceived as present in their countries of origin.

Judeline also recalls a painful transition as she confronted what she perceived as her children becoming assimilated into American culture:

It’s a different culture. Here, even my kids, now it’s okay if they don’t call me. Before that, that used to traumatize me if I didn’t hear from them. I have to call them every day. I said, “Okay, now you spread your hand so far you can’t even have the chance to call me for one second, to say ‘Mom, how are you doing?’ You don’t even care about me any more to give me a call?” Now I understand. That’s fine. They’re too busy. I accept that. They have their own life. I always call my mother. I never pass a week without going twice to see my mother. If she needs something I will call and say “I’m going to the market, do you need something?” Here are two different cultures. Back home they teach you to care about your parents. That doesn’t mean here they don’t care, it’s too different. Maybe it’s a different environment; the work and everything. Back home we have more time. Everything is according to the time.

Judeline’s remarks illuminate how both states and individuals can have distinct norms and roles that shape practices of care. Different states, and by extension,
different individuals carry different “logics of care” that are dynamic over time (Williams and Brennan 2012). What it means to be a productive citizen in the U.S. and Haiti may seem dichotomous, but Judeline argues that neither form is quantifiably better. Rather, while the state “takes care” of its elders in the U.S., the family takes care of theirs in the countries of origin.

STRONG BONDS, WEAK STATES: PERCEPTIONS OF CARE IN THE COUNTRIES OF ORIGIN

The Deserving Elderly

While they perceived the U.S. government as fulfilling a public responsibility to care for elders in the Greater Boston area, the caregivers use a similar language invoking reciprocity when describing how families come to take on caring responsibilities in the countries of origin. Promoting the ideology of filial piety, these caregivers believe children should “give back” to the parents that raised them. Samuel explains:

There is an ideology in Haiti. Basically their children will take care of them and there’s a common belief that having children is almost like - they always say the popular proverb that says that having children is like to store the money in a bank, that when you get old they will take care of you. That’s how they think it and that’s the basic thing that happens. The children are now work, but they will take care of their mother, of their family. For the most part they are very family oriented. That’s how they take care of each other whether they are old; a cousin
will accept my mother in her house and treat her like her mother and take care of her, correctly.
In her research, Pei-Chia Lan (2002) explains the importance of the tradition of filial piety in Chinese families. She writes: “Child rearing is viewed as a process of social investment with an expectation of delayed repayment, or in Chinese, bau-da (payback). Parents undergo economic and emotional costs in bearing and raising children, this tradition stipulates, so children, especially sons, are obligated to return the debts through provision of care for their aging parents” (Lan 2002:169). With tears in her eyes, Renata expressed her desire to provide for her aging parents – her mother and father, who, despite having little in the way of finances, offered her a happy and loving childhood:

We had a lot of necessity, you know, because it’s a poor country and my family was so poor, but we had a lot of happiness around my father and my mom. A lot of good memories back in my country, yeah. I have a beautiful family. Always together, cooking together, cleaning the house together. And that thing I think, nothing can replace, my feeling when I was little. We had a lot of necessity, you know, because sometimes I wanted to have some shoes and I couldn’t have them because they didn’t have the money to buy it. But for that reason, everything that my mother needs, I will give it to her.

Despite the diversity of the sample, many of the caregivers in this study promote similar notions of obligation and commitment to caring for their families. But as Samuel’s quote reveals, the migrant’s definition of the family often expands from the nuclear form to include extended family and at times, the broader
community. As will be discussed further in the next chapter, these transnational caregivers not only felt responsibility to “give back” and “care” for their parents, but also to provide for their community as a whole through economic and social remittances (Agius Vallejo and Lee 2009).

*It Takes a Village: Conceptualizing Care for a Community*

Junior took care of his grandmother in Haiti when his mother migrated to Boston. Efie was the first of her immediate family to migrate to join her uncle in Boston and was left to fend for herself once he moved to Texas. James grew up watching his single mother take care of her parents at their household in Kenya. Despite the range of different biographies and migration trajectories, a common theme across all of the interviews was the abundance of communal and familial support present in the countries of origin. Indeed, almost all of the participants recalled that regardless of their family structure, from growing up with a single parent to leaning on the multiple wives of one’s biological father, there was always someone around to “take care” of aging relatives, babies, or even a hungry or tired stranger. As Sharon, a nurse from Kenya fondly remembers: “If we were in Kenya and I wanted to go the stores, I would just tell [my neighbor], ‘My kids are outside playing. I’m just going to go to the store.’ She’ll be okay with it. I would be watching her kids too. If she’s an older lady, she wouldn’t be
living by herself; she would be living with her family.” This theme of interdependence at community level carried through each of the interviews.

All of the participants deemed family and neighbors to be the primary source of care for the elderly in the countries from which they migrated. Naomi explains:

Well the U.S. is really a developed world and financially they are stable. They have everything that is needed in the health field and they are able to pay people. There is money to be paid to pay people to take care of other people. It doesn't have to be family members. Cameroon is not like that – we’re not like separated from each other. Extended family is all involved. The care is not only on one person. Family members take turns in caring for their own elderly or anybody who is sick: mother, father, grandmothers, grandparents. We take care of them ourselves. There are no homes for them to go or to live at. The care is pretty much done by family.

When the participants make judgements on caring responsibilities, then, their sphere of concern involves care recipients beyond blood relatives. Efie also clarifies the construction of the family in Ghana as a unit that encompasses members beyond the immediate nuclear family:

Yeah, I mean, friend, family, you know, it’s a long, long family. Back home everybody is our sister. It's not like here, where you specify. Like you say, “Oh, this is my cousin. This is my half-sister. This is my brother.” Back home we are all sisters and brothers. Even if it's my auntie's daughter or whatever, I consider her as my sister. There's always someone to help. Here you have the difference. You say, “Oh, this is my cousin’s blah, blah, long family.” You know?

Michelle also cites differences between how Americans define family and how
Haitians conceive of family and caring responsibilities. She believes that the practice of closeness valued in her culture ensures that there will always be someone around and willing to “take care.”

Michelle: In my country, people keep together, even if it’s not your family. This country is different than my country. It’s different. People touch each other in my country. Even if we only have one banana, we share with people. That’s the way my country is. My father would set up a big tent on a rainy day and he would share with people. Even for people who have nothing to eat that day, they will have one week to eat easily because people share with people. Yeah, they do that in my country. In my country, you have these clothes; you are the same size, you can share with her. People are more personal in this country. I accept that because it’s different country. In my country, a sister, my aunt, and your aunt all seem like your mother. Your uncle seems like your father. That the way we do in my country.

Sahra’s fond recollections of her childhood offer another image of a close-knit caring community before the Civil War:

My life, growing up in Somalia at that time, was beautiful. Even though my country is not a rich country, the life is easy. You live with your aunties, your family, your uncles, friends. You run around, go to your uncles’ houses, your aunties’ houses, your friends. You grow up with your neighbors. Those times were very nice.

The extensive support systems in the countries of origin took on a feature role in the narratives of these immigrants when they discussed their expertise at caring for their clients who they portrayed as fictive kin. Images of their close-knit communities were often evoked during discussions about the isolation they perceived in the United States – not only towards their clients but also in their
personal experiences. Recalling his earliest recollections of the United States, Samuel describes the culture shock he felt coming from a “philanthropic” community to an individualistic one:

There are a lot of things that you come across, like for instance, we have what we call philanthropic relationship to each other over there; the neighbors playing dominos together and on the street everyone is connected to each other. But here the difference is you’re stuck in the house. They don’t know you, they can pass by you and they don’t even say good morning, that was the biggest insult it could be in our country, pass by people. Even you don’t know them you’ve got to say good morning!

Kwesi also misses the communal culture he left behind:

Megan: What do you miss most about Ghana?
Kwesi: Family. I miss the family; miss my friends, and the little things that we'd do that we don't get a chance to do here. Over there it’s more like a community arrangement. People get together, we get together in evenings. You don't have to call somebody to say I’m coming to visit you. We miss that close connection and family closeness. We miss it very much. Over here, a lot of people are very busy. You may even have the close family in Africa. When you come over here, the relationship is not as close as it used to be. Because of the pressure in society, the demand for everybody here – everybody seems to be materialistic.

Kwesi notes the structural pressures the U.S. imposes on interpersonal relationships, but ultimately relies on a cultural frame to understand the different ways of caring he observes in both Ghana and the United States. When imagining the strengths of their nations’ systems of care, then, these caregivers often posited a romanticized vision of an untainted communal culture with strong moral values (Espiritu 2003).
“But we do have love”: Emotional Care, Being There, and the Lack of Affordable Geriatric Healthcare

The stories of familial caregiving in the countries of origin contain the common themes of “being there,” “sharing,” socializing, and helping out with everyday tasks. Therefore, when these immigrants spoke of “caring” responsibilities in the countries of origin, they focused on the emotion work of building relationships coupled with basic ADLs such as cooking, cleaning, and transportation. Myra describes the important roles offering love and displaying attention play in caring tasks in Cameroon:

Cameroon they try, but financially they don’t have, but they do have love. Even a neighbor can come in to make sure that they are safe, even though they don’t have the financial means to take care of them. They live their communal life. Their problem is mine, their joy is mine. They are always there for them even though they don’t have the financial means to help them but they are there.

Beverly also highlights the altruism displayed in Jamaica. Like Myra and several other caregivers in this study, she believes that interdependence is a cultural trait to be valued, and that despite a lack of finances, other behaviors such as watching over one’s family members or picking up a stranded friend on the side of the road are important forms of “helping out”:

Beverly: Back home, if you need a hand, you might call somebody. Or, if you’re on the street and if your car breaks down, people will help. Back home, from the moment somebody sees you break down, five or six cars stop to help you. You
don't see that here, so it's quite different from back home. Sometimes friends volunteer. If you're back home and you have a baby, you might have an appointment to go somewhere. Friends or family, they will help. They help you to take care so that you can go to your appointment. They take care until you come back. Family sticks close together.

Contrasting images of lonely and isolated elders in the United States, these caregivers felt that physical company and attention were readily available and necessary in the countries of origin:

Fabienne (Haiti): When we were little, my mom and her sister in law, everybody helped out. Back home, it's not the same as here. If you have people who are sick, and they have family who are living elsewhere, the community will help them. Sometime they sleep with you; they help you. If one person cannot [help care] during the day, you will take care of him, and then during the night, he will take care of him. So, if you go to the hospital, and then you come out and go to your house, people will take care of you. Everybody will have a turn.

Unlike senior citizens in the United States who might transition from the hospital to a rehabilitation facility or acquire visiting nurse services, Fabienne expresses that family members and the broader community take turns in providing care around the clock.

In addition to paying attention and collectively monitoring, these caregivers also felt it was the family’s responsibility to perform basic ADLs. Stephanie exudes pride as she describes caring for her grandmother after a stroke: “My grandmother, before she died, she was incapacitated for thirteen days. She could not walk; she could only sit because she’s really big. We really
took care of her. If someone came by the house, they wouldn’t know that she can’t walk because we gave her good care. She was really clean. She felt really nice.” Like Fabienne, Stephanie noted the role of the family in transitioning the elder from hospital to home. Although she could not help her grandmother move around physically, she felt the efforts of “keeping her clean” were essential to providing quality care to her grandmother.

Despite the generosity articulated in these stories, many of the caregivers acknowledged the detrimental absence of public safety nets when it comes to providing and paying for skilled healthcare. Care that took place in the homes centered on emotional labor and basic ADLs, and more serious emergencies required transport to the local hospital:

Efie (Ghana): Everything is totally different. Here there are nursing homes. Back home, in my country, we don’t have any nursing homes. I never saw a nursing home in Ghana. But we have hospitals. They will go to the hospital and then stay there. When they get discharged, they come home. Then we [the family] take all the responsibilities to care. Here they have assisted living, independent living, where they can take them if … like if they keep falling at home. They need supervision for eating and stuff. They have places that they can take them for assistance, but back home is not like that. They are home.

In addition to lacking skilled geriatric care facilities, many of the caregivers noted the exorbitant costs of quality healthcare. These caregivers perceived that affordable health insurance either did not exist or was only “affordable” for the
wealthiest citizens of their nations. Thus, responsibility to pay for healthcare in the hospitals fell on the families:

Mirlande: The government here is more organized than Haiti. They give you more opportunity. If you can’t help yourself, they have help for you. If you know where to go and how to get help, you can get help. In Haiti, if you can’t help yourself, no one cares about you. They care about their pocket, their family, but they don’t care about you. And they don’t have an institution where you can go to ask for help. They don’t have that.
Megan: So are there any other avenues to get help besides the government in Haiti?
Mirlande: There are NGOs from here. It’s like a non-profit organization that went over there. They do something, but they cannot do much. They can’t do much because even though they are a non-profit organization, they are still working within the government walls, you know. So there’s nothing you can do. So it’s up to the family members… We don’t even have a good hospital. We have the general hospital which is the main hospital in the country. It’s not working.
Megan: It’s not working?
Mirlande: No. It’s not working. No. They don’t even have first aid over there. If you bring somebody to the hospital, they have to buy their own medicine. If they don’t have money to buy the medication, the hospitals should be able to provide the medication and bill the patient later or – you see the system of insurance that we have here, the medical insurance that we have here – they don’t have that in Haiti. You need to have your money. If you seek to see a doctor, you need your own money.

When referring to who is responsible to pay the economic costs of eldercare,

Mirlande renounces the government of Haiti for not sharing in the interdependent spirit of its citizens. To her, the lack of social welfare promotes a capitalist state that is at odds with the ideals of a caring culture.

Thus, the availability and quality of medical care for seniors in the
countries of origin is intimately tied to the political economy. According to nearly all of the participants, most healthcare expenditures were out of pocket, leaving those who could not afford treatment at risk.\textsuperscript{19} With excessive pressure on individuals, especially migrants, to take care of their communities both emotionally and physically, providing enough financial support becomes overwhelming and the sphere of “the family” justifiably narrows. Rachelle expresses frustration over the high costs of healthcare in Haiti:

If you’ve got good family in Haiti, and you have money, they can take care of you, but if not (wipes hands) it’s really, really difficult. If you come in the U.S. right now, you get care. In Haiti now, after the earthquake, if you have to go to hospital, you have to buy your own needles for them to give you an IV. Even if you have to go to the hospital you have to bring your gloves. Hey, that’s not a life.

Rachelle’s perception of the resource deficit in Haiti directly shaped her future retirement plans. When asked where she thought she would be in ten years Rachelle responds:

Well, I think after ten years, I’ll probably be here because over here it’s not too bad, because elder people have social security. You can have food stamp. You can have welfare. But in Haiti they have no food stamp, no social security, nothing. My dream used to be to go back to Haiti, but everything changed.

\textsuperscript{19} Participants from Jamaica, a country that has some semblance of state-supported eldercare with options for home care and established nursing homes, focused on the perceived “untrained” quality of care within the institutions rather than the government’s general failure to address and assist geriatric populations. These negative assessments of the programs, however, rendered the public provision ineffectual and left the Jamaican caregivers in a similar situation of taking responsibility for the cost and quality of eldercare for their family members.
After 2009, they killed my brother over there. They hit in the head and killed him. He was in Florida and he went back over there to visit. After two weeks, they killed him. But I'm not like scared about that, you know? My problem is, I only have the one son. I got the one big house over there. I have to sell that, get the money and come over here. It's better for me, because my son doesn't like to go over there. After that I'm not scared to go, but not like to go and stay. Before, my dream was to go to Haiti because you know, I can have my social and money come to me. That's my dream, but after 2009, nope.

For Rachelle, the lack of liquid assets besides her large house and her brother’s unfortunate demise left her in a tough situation that would leave her without a caregiver should she decide to retire in Haiti. The reluctance of first generation and 1.5 generation children to move to Haiti was a prevalent theme throughout the interviews also that shaped perceptions on care and anticipated plans for retirement. Given that these caregivers felt medical care was unavailable or too expensive, when the safety net of familial care was removed from the equation, pull-factors of the U.S. outmaneuvered those of Haiti.

Despite the claim that “someone was always around” to help care in the countries of origin, when these caregivers draw comparisons with the U.S. Social Security and welfare programs, they note that such benefits would help those elders without a local familial support network that can help cover the costs of medical care. Here they offer the distinction between familial or community-based casual provision of ADLs and emotional support from the housing,
advanced medical facilities, and medical insurance benefits that isolated seniors receive in the United States. Although the image of an elder who needs housing and services seems contradictory to the claims of abundant familial support, the emphasis on the type of care maintains a positive perception of a “caring culture” distinct from an uncaring state.

MIND OR MATTER? DETERMINING THE REASONS BEHIND ELDER ABANDONMENT

These caregivers assessed caring responsibilities and made judgments concerning the type of care necessary based on real and imagined experiences with systems of care in both sending and receiving countries. While highlighting the perceived cultural prowess of communalism provided a useful identity strategy for immigrant caregivers, their concrete experience as migrants in the U.S. offered another lens from which to view the chronic problem of elder “loneliness.” The presence of a black immigrant niche in direct care directly corresponds to the undervalued nature of the job. As explored in Chapter One, the “lower skilled” positions as the bottom of the nursing hierarchy, the level to which people of color and immigrants have been relegated, offer little in terms of pay and benefits. Additionally, the precarious nature of the work, especially for
home care aides who may lose income when a patient leaves for the hospital or passes away, often requires these caregivers to take on extra work to make ends meet. Many participants made sense of the need for paid caregivers in the United States, then, by reconciling their experiences with having to hold multiple jobs to survive in the U.S., with the culture of individualism and self-sufficiency to which they were exposed in their everyday interactions at home and work. In citing the weaknesses of the U.S. care system, Myra, a CNA from Cameroon quickly blames the absence of filial piety norms in American families: “The weaknesses could be like maybe some families are not willing to take care of their own parents. Even though they have the money, they still get somebody else to take care of their parents, which I see that as— it is your parents! They brought you up, they took care of you all your years and the minute they can’t do it for themselves you send them out or get somebody else to care for them.” She contrasts this scenario with Cameroon where she sees “everybody, aunties, uncles” getting involved in care for family members. After a beat, Myra adds, “And maybe too it’s the time, like the jobs and all that, so they are too busy to care for them. And the family is not involved, like the aunties. Like maybe the mother and sister would be like ‘it’s your mother, you care for them...’” To understand the eldercare system in the U.S., Myra uses both a cultural frame and
an economic frame to form her evaluations. She recognizes differences in the
U.S. notion of the family and responsibilities from the communal nature of
extended family care to which she was exposed in Cameroon. Efie, a CNA from
Ghana, also altered her opinions about nursing homes upon her immersion into
a life of constant work and isolation from friends and family:

I would keep my mother or grandmother at home if I can, because I want to be
close to them to see what their conditions are, to know what’s going on each and
every day. But here, it’s good, too, to take them away, because here you …
number one, you have to work. You can’t skip work and say, “I’m staying with
my mom.” How you going to pay your bills? How you going to do whatever
you are supposed to do? I think that is the main reason why people take their
loved ones to a facility where they can get help for them and they can also work
and then do the necessary stuff. I don’t think it’s a bad idea. Because when you
come … Like, if I haven’t been here before and someone here is telling me, “Oh,
America, they take their family to the nursing home, assisted living.” I would
say, “Oh, are they crazy?” But when you come here, you will know the reason
why. You know? You know the reason why they do that.

While Efie still hopes to care for her aging relatives in a familial setting, she
recognizes the pressures of work as interfering with family time.

Alternatively, when discussing their migration experiences, several
caregivers described supporting their families financially as their motivation to
leave the countries of origin. They subscribed to the narrative of the American
Dream and anticipated a more favorable job and education climate than that
which they experienced in the sending country. Although viewing a stronger,
tightknit culture as the reason for abundant familial care was more amenable to identity strategies of these immigrants, some participants made connections between the lack of jobs available in the countries of origin and the availability of family members, neighbors and friends to take care. According to Elisabeth, “Everybody is working here. Everybody’s busy so that’s why they have to pay someone to care. But in Haiti it’s different. They don’t have jobs so you have to take care of your family.” Ricardo echoes this point: “Because here, nobody has time. Back home, people go back and forth all the time because not too many people working. You have people home all the time. When my mother was here, sometimes we leave her home with someone, but you have to pay someone to sit with her. She was not too happy here.” Although Ricardo encouraged his mother to migrate to the U.S., he quickly realized that she felt isolated due to his long work hours.

Although these caregivers note the benefits of safety nets for deserving elders, they rarely advocated for changes to policies regarding the relationship between work and time. Instead, they embrace full responsibility to manage care by whatever means necessary, even if it meant leaving one’s family in the countries of origin to make money or taking on multiple jobs in the U.S. to send to family members abroad. Despite recognition of global inequalities resulting
from neoliberalism and the retraction of the state, however, these caregivers often rested on cultural explanations that posited static differences. Rather than fundamentally challenge this ideology altogether, these caregivers developed practices that conform and work within structures of neoliberalism.

Achieving a Healthy Balance

Perceptions of care cultures and state regimes are quite important in shaping the care behavior of this niche. These caregivers foster new ways of thinking about care after taking into account these structures. In other words, dual evaluations of the availability of government services for elderly in both the United States and in the sending country affect perceptions of personal responsibility. These perceptions engender practices that, in turn, create new practices and identity options. In negotiating how they should take care of aging relatives and in determining their own aging plans, participants occupied a space between seeing communal values accentuated in a climate of government abandonment in certain sending countries and a strong welfare state accompanied by familial abandonment in the United States.

The Quest for Holistic Healthcare

Comparing different norms and policies surrounding care helped these caregivers compose a comprehensive definition of care as an equal emphasis on
physical and emotional care. These caregivers highlight the reciprocal nature between feeling good emotionally and feeling good physically and strive to facilitate such positive states for their families and clients. Esther, a home health aide with experience in both home and institutional settings, believes that without love, which she articulates as both “being nice” and attentive to a client’s medical needs, people succumb to death faster than they would with a helpful and compassionate caregiver present:

Esther (Haiti, HHA): The most important [task of my job is] to give love; to be nice; make them happy; encourage them. And if something hurts, “take the medication, you will be better.” Encourage them to know that they are safe, and that they will be better. You know you have to do that, because when you are sick and something hurts you, when you’re sick and you have no affection, you have nobody to do something for you. If you will die in ten years, you will die in five years in that case. Because you miss everything. And now you don’t have any affection or someone to say to you, “Oh, you need some medication. You’ll be OK.” You need somebody. And when you have someone to help you and to encourage you - that makes you have more life, live longer.

When asked what they considered to be the most important task of their paid caregiving jobs, these caregivers frequently noted that along with building relational bonds, attending to small details like maintaining a routine and “putting things where the client can find it again” can be just as important as keeping the client clean and hygienic. And, as will be discussed further in Chapter Five, caregivers, especially those who work in institutions, perceive very
real emotional benefits resulting from careful attention and response to the physical tasks of eldercare, or what is often referred to as “the dirty work” (Stacey 2011). Thus, these caregivers view tactfully assisting with activities of daily living (ADLs) “such as eating, dressing, bathing, and toileting” in addition to “housekeeping chores, meal preparation, and medication management” (PHInational.org 2011) as going a long way in providing comfort and dignity for the client. Along with delivering tailored emotion work including encouraging independence, practicing patience, and treating the client with respect, physical care is very important in caring for the “whole person.” Emeka explains, “Everything I do for them is important because these are lives. They are human beings.”

In recognizing the importance of providing quality care for frail elders in need, taking responsibility to provide exceptional care for their families and clients, and determining holistic healthcare as the best approach for eldercare for their families and clients, these caregivers foster new ways of thinking and acting that alter the social organization of eldercare across borders. The perceived lack of government social protections, particularly regarding the absence of affordable healthcare in the sending countries and the emotion-prohibitive structures of government-funded geriatric care in the United States, motivates
these transnational caregivers to take responsibility to fill the voids. The
following two chapters explore their construction of personal responsibility to
provide wealth and medical resources for their family members and emotional
support and physical presence to their clients in the United States in attempts to
achieve a balance that ensures dignity for aging populations across the globe.
Myra (Cameroon): I expect that I will be able to take good care of them as much as they did for me. Provide for them. My grandmother, she pretty much depends on me. I am her provider for anything right now.

Megan: In what ways?

Myra: Financially…even her health. All her medications, I take care of that. If she has to go to the hospital I will know why she is going. I make sure the bill is paid at the hospital. Anything that she needs I make sure that I provide it for her…I am glad I am in the United States. I am really, really glad. My grandmother, where she is now, she doesn’t have to do so much. I tell her, “Do as much as you can but don’t do too much: some exercise, keep active.” She has everything that she needs right now, as long as I am here.

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Throughout the interview, Myra beamed as she talked about her grandmother. Just minutes after wiping away tears as she reflected on the heartbreaking work of caring for severely disabled children at the pediatric nursing facility where she worked part-time, a smile appeared on Myra’s face as she talked about her anticipated trip to Cameroon where her children would meet their great grandmother for the first time. Myra had been teaching her two young children the tribal language she grew up speaking in Cameroon in order to surprise her grandmother and assuage her fears about missed communication due to language barriers.
It was obvious that Myra had a special bond with her grandmother, the woman who raised her when her mother passed away and her father migrated to the United States. Now, as her grandmother begins to feel the physical and economic effects of old age, Myra’s role has shifted from that of the care-receiver to the caregiver. Due to her status as an immigrant living in the United States, Myra feels more economically secure than her grandmother’s children currently living in Cameroon. She views herself as the primary caregiver and she speaks of this role with pride, believing that her grandmother’s quality of life is better than it would be had she never migrated. Such commodification of caring is consistent with Myra’s family background. Indeed, growing up with parents who traveled often, Myra recognized a form of love as providing for a relative’s needs with financial support; a theme consistent to several other studies on transnational families (Coe 2011; Hondagneu-Sotelo and Avila 1997; Parreñas 2005). Despite her confidence in her role as primary caregiver, Myra explained that she worries about her grandmother withholding information from her about

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The grandmother who Myra references is her late mother’s mother. Myra notes that because her parents were never married, her father never felt a filial obligation to care for Myra’s grandmother beyond occasionally giving Myra money to send to her. While her story rings familiar to other gendered transnational family stories, her father’s minimal involvement reflects a rejection of familial reciprocity as opposed to gendered transnational behavior. Other male caregivers demonstrate an alternative narrative to gendered remittance activity by engaging in various forms of transnational caregiving for their aging relatives (Dreby 2010; Parreñas 2005)
ailments and money problems. Recent research has documented this growing problem for families with transnational aging parents who fail to provide critical health information that they worry might causing stress for their migrant children (Baldassar 2007; Ballock 2003). Myra ultimately wants her grandmother to join her in the United States so that she can be present in her daily care while continuing to fulfill her needs economically and medically, a goal maintained by many participants in this study by virtue of their immersion in the field of paid caregiving.

Myra’s story is illustrative of not only the diverse family arrangements present in the sample of participants whereby care extends beyond the Western-centric view of the nuclear family, but it also reflects the pressures faced by participants to stay in marginalized work situations in order to maintain a steady income to provide for their families abroad. These immigrant caregivers feel an immense amount of personal responsibility to provide care for their relatives at whatever cost, viewing their elevated social position with respect to “non-migrants” as a byproduct of their families’ sacrifices in raising them and supporting their immigration. Whether fleeing from civil or political conflict, joining family members already living in the United States, or searching for occupational or educational opportunities for themselves or for their children,
the participants in this study moved to the United States in search of a “better life.” In their eyes, the “American Dream” was not a goal to be achieved for individual benefit alone; the pursuit of success and stability mattered for their families, and in many cases, for entire communities. These feelings of reciprocity and obligation are common to other immigrant groups who desire to “give back” to those left behind. In their work with Mexican immigrants, Agius Vallejo and Lee find that when deciding to send remittances to their communities, immigrants subscribe not to a purely collectivist narrative or individualist narrative, but rather to the “immigrant narrative”:

[The immigrant narrative] recognizes and rewards self-sacrifice on the part of the immigrant generation, which, in turn, leads to their willingness to offer assistance to their parents, siblings and extended kin (even those who are not related by blood). By clinging to the immigrant narrative, they feel that they cannot turn their backs on less privileged ‘family’ members – regardless of how distant the connection” (2009: 21).

Such subscription to the globally pervasive “American Dream” ideology whereby opportunity is readily available to those who merely work hard enough increases their sense of obligation to provide care.

To be sure, the story of immigrants working multiple jobs and sacrificing comforts in order to send remittances to their families is not a new one. What is unique is the type of remittances and care practices these immigrant caregivers
transmit to their families by virtue of working in paid eldercare and living in the transnational social field. As discussed in Chapter Three, occupying this specific social location offers these immigrants the chance to evaluate broader systems of care and determine their care practices accordingly. This chapter explores how the desired goal to ensure quality geriatric holistic healthcare intersects with ideas about the perceived feasibility of affecting change at the systemic level to shape concrete eldercare practices towards aging relatives. Through sending financial remittances and eldercare specific equipment, contributing social remittances in the form of educating family members on care techniques and hygiene, and encouraging aging family members to migrate for care purposes, these immigrants actively change the climate of eldercare in their countries of origin.

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CARING OFF THE CLOCK: HOW CAREGIVERS VIEW INFORMAL CARE RESPONSIBILITIES

As discussed in the previous chapters, participants’ perspectives on the state of global eldercare are influenced by a collision between the knowledge production gained through their entry into the field of paid carework in the U.S. with their habitus and the capital (social, economic, and cultural) developed
prior to migration. In paid carework, for example, caregivers combine their prior knowledge of informal compassionate caregiving from their own upbringing with the newly acquired techniques of medical care and training that they learn on the job to execute excellent physical and emotional care for their clients (Stacey 2011). Less often explored in the literature on transnational care chains are the processes whereby knowledge gleaned from the profession engenders new concepts of care for family members “left behind.” The stories in this chapter reveal that the human and intimate nature of such work encourages caregiving knowledge production to transcend past the walls of work and influence care that these caregivers provide informally to families. The relationship between informal and formal transnational eldercare is reciprocal then, and the actions of these caregivers represent agency in altering eldercare institutions in both the sending and receiving countries.

Policies regarding welfare, immigration, and labor all influence care arrangements for transnational families. In addition to government policies, these immigrants also condition care practices on perceptions of different “care cultures” and the availability of family members to provide care in the absence of institutions. From the initial decision to immigrate to determining where an ailing family member should seek medical attention, immigrants make
judgements on how to best provide for their families (Bashi 2007; Kilkey and Merla 2014). Thus, practices of care are negotiated based on the amount of economic capital and social capital that is not only available but also able to be utilized in an atmosphere of institutional restrictions, government or otherwise (Kilkey and Merla 2014).

To date, many scholars of transnational family dynamics have emphasized the precedence emotional care and nurturance take over physical or “material meeting” of the care need when caregivers and their dependents fail to live in close proximity to each other (Amin and Ingman 2014; Baldock 2000; Parreñas 2005; Sun 2012; Zechner 2008). In their study with Bangladeshi immigrants in the United States, Amin and Ingman find “emotional care” to be “the most important aspect of transnational elder caregiving” likening encouragement and mental support and frequent expressions of grief and remorse to the “Caring about” phase of Tronto’s work (2014:322). Ken C. Sun (2012) also presents evidence that middle-class Taiwanese immigrants emphasized the emotional support they provide their parents as fulfilling the expectation of filial piety and that behaviors like “checking in” had greater symbolic value than practical value. Nurturing and “martyrdom” are particularly resonant care behaviors for transnational families with mothers
separated from their young children (Dreby 2010; Parreñas 2005). Indeed, the symbolic notion of a precious childhood combined with gendered nuclear family expectations opens the door for negative press bemoaning mothers “abandoning” their children, forcing transnational mothers to overcompensate with tailored emotion work (Parreñas 2010). Throughout each of these situations, caregivers made judgments concerning the most useful way to articulate care for a family member in need.

The responses of the caregivers in this study reveal an alternate reality where the inverse is true: when they think about caring needs and decide how to account for those needs, these caregivers detect a resource deficit for aging populations in the countries of origin and tailor their transnational caring practices to fill the perceived void. To be sure, these caregivers maintained close emotional relationships through frequent phone calls, social media, and letters home, but their constructed definition of “taking care” focused on the economic and social remittances that contributed directly to the physical health and wellbeing of their aging family members, friends, and communities. With a new awareness of available and affordable medical technologies, these caregivers developed a moral obligation to help elders live healthier and happier by alleviating their physical ailments.
“These are my parents. This is my responsibility”: Gender and the Assessment of Caregiving Roles

As Myra’s case illustrated at the beginning of this chapter, although not physically present in the countries of origin, most of the respondents reported feeling personally responsible to care for aging relatives and friends abroad due to the context behind their migration or cultural obligations of filial piety. Guided by a common perception that families are responsible for managing care in the country of origins, participants mentioned sending financial and material remittances and/or frequently communicating by means of phone, email, social networking sites, and in some cases, visiting. Feelings of responsibility were enhanced by notions of gender roles, perceived expertise at caregiving tasks, and the belief that other individual or institutional help was not available.

The literature on transnational families tends to highlight the feminization of migration and the consequential reconceptualization of motherhood and fatherhood roles. In these stories, caregiving often affirms gender roles with the added burden of breadwinning for mothers who migrate (Dreby 2010; Parreñas 2005). Similar gendered divisions of labor appear in the few studies that have explored transnational eldercare – with daughters or daughters-in-law taking on transnational emotion work and sons occasionally contributing financially (Lan
The caregiving practices of the male and female caregivers in this study reveal a different, more gender-neutral transnational caregiving story, despite the perceptions of the female participants that often presume responsibility according to defined gender roles. These findings are consistent with Baldock’s assessment of transnational eldercare practices among college faculty and administrators who migrated to Australia from the United Kingdom:

Literature on carers (e.g., Ungerson 1983, 1990) tends to see caring as a gender-specific issue...However on the basis of the data I have collected so far, a simple gendered construct of caring from a distance cannot be maintained. I found that male and female interviewees retained close communication and support networks with their parents; sons as well as daughters made the frequent trips home to care for and comfort these parents. Male as well as female migrants relied on (or could not rely on) siblings back home to provide care...Inasmuch as gendered care did occur, it related to the type of tasks performed: It appeared that male migrants (as well as male siblings back home) were more involved in looking after business affairs, repairs, or maintenance issues, and women were especially (but by no means exclusively) concerned with health issues and with emotional support. (2000:221)

Exploring the intersection between gender and remittance activity from immigrant children to their parents overseas, Stephen Raymond Kodwo’s (2009) dissertation also found that instead of overtly gendered care, the dynamics that primarily shape attitudes toward international eldercare patterns among Ghanaian immigrants to be determined by: “The support caregivers receive (or
previously received) from elderly relatives; filial obligation toward elderly relatives; perceived vulnerability of elderly people in Ghana; and vulnerabilities that make immigrants unable to provide eldercare” (2009:xi). Indeed, all ten of the men in this study described frequent transnational contact and care such as sending “money transfers, and sometimes food and big boxes of items and clothes,” “calling often,” and visiting when possible (Interview with Edouard), articulating similar “types” of both economic and emotional remittances as their female counterparts. The stories of the male immigrants in this study are unique because of their position in the global care chain as paid caregivers for the elderly. Along with notions of filial responsibility and “giving back,” these men feel confident in their abilities to care by virtue of working in the field.

Despite these claims of shared responsibility and similarities in caregiving practices among all fifty participants, many women in this study believed their gender category stipulated a greater responsibility to initiate care for their aging relatives when compared to men in their countries of origin and those who have not migrated. Nathalie felt an immense amount of pressure to take care of her family members in Haiti because she views her brothers as “uncaring”:

Megan: If someone needed to help them to get around and do some of the things that you help elderly people here with, would one of the other family members do it? Would you hire someone to help them out if they needed help?
Nathalie: No. I help them by myself. I have a lot of responsibility. Too much! I help take care of them. That’s my responsibility.
Megan: What about your other siblings?
Nathalie: No. Just me, not my brother.
Megan: Why is it just you?
Nathalie: I don’t know. He’s a man. They don’t care about nothing. The women must take care of the family.
Megan: How do you feel about that?
Nathalie: These are my parents; this is my responsibility. This is my problem. I have to take care of them. Because, I love my mother. Ah, yes. I love my family. Yes. That’s why I came here. I try my best to do whatever I can do to help them. I really, really love my family. I care for them. I really care for my family.

Like Myra and several other participants in this study, Nathalie recognized the obligation of care as stemming from the fact that she migrated in order to provide for her family. Likely due to the fact that her parents are still independent, needs of ADLs did not resonate with Nathalie. She reported sending money, food, and traveling to see her aging parents in Haiti. Nathalie felt it was her responsibility to take care of her parents, even from afar, and she defined her role as natural due to her position as a daughter in her family.

Nadine (Cameroon) and Judeline (Haiti) and Beverly (Jamaica) echo Nathalie’s essentialization argument:

Megan: When people decide to take care of their aging family members, is it usually women that do care work, or is it sons and daughters that share it pretty evenly?
Nadine: Ah, generally women [take care of aging relatives]. Yes... Except if you have a very nice daughter-in-law, the son can also take care. But generally it is
the women. The girls take the mothers, the parents, to their house.
Megan: And why do you think that is?
Nadine: I think they know that, the aging parent is like a lot of work. So the daughter is more patient, more predisposed to do it, than the son.

Judeline: It’s always women.
Megan: Why do you think that is?
Judeline: I think it was part of the culture. Men always are busy back home. The way they raise men, it’s like they don’t do that much. Even when you get married it’s a problem for them to help even when they have other siblings like sisters. They have the sisters do all the work.

Beverly: Usually, then the men will chime in sometime and help to do the food. Like help the family with the food and everything. Because they are – we think they are men, they are not supposed to take care of them. So we only need the help if they are heavy enough to help us. The men can chime in and help us to do lifting. Otherwise we do the care. Ladies are supposed to do the care.

Each of these women recalled a gendered division of labor in their households prior to migration. Perceiving these roles to be “natural” and intrinsic to their cultures increased these women’s feelings of personal responsibility to manage care for their aging relatives. Although some recognized male contributions in the form of breadwinning or doing tasks believed to be masculine such as “heavy lifting,” these women believed that female relatives “care more” and are predisposed to it due to their “patient,” “sensitive,” and “thoughtful” natures (Interview with Yadira).

To be sure, several women in the study remembered more egalitarian caring roles in the countries of origin. To them (and the male participants)
everyone in the family had an important role to play in caring, as Samuel articulates, “If a family member becomes paralyzed, any member of the ... every member of the family contributes.” Although the tasks may have been distributed according to perceived gender roles, these caregivers noted that the sum of the parts added up to holistic “quality care.” Michelle explains:

That’s the way we were raised in my country. Everybody is supposed to do something, to learn something, to cook. Even at ten years old in my country, the kids wash their clothes and iron the clothes; you cook and prepare everything. My brother went to prepare the vegetables. My father prepared the meat. Everything is taken care of by the family. The girls clean the house; prepare the food; that’s what we do in our country. And you clean your clothes. That’s why when we come here, we aren’t scared of anything. You work. You make money. You send money to your family. Because you know nothing is easy; everything is so hard. It was the same in my country.

Alternatively, Sahra explains that while entire families share caring responsibilities in Somalia, tasks are divided and matched according to the sex of the caregivers and care recipients:

Megan: So when it comes to like cleaning, and home care type of work, is it women or men that usually do that or do both?
Sahra: No if that person is a man, the man takes care. He gives him a shower. If the man has a wife, she can give him the shower. But if his wife can’t help him, the other men, grandson, his son, the other family takes care of him. And the food, cleaning, the laundry: everybody does that job! (Sahra laughs)
Megan: But for bathing, it’s men - sons to their fathers, or wives to husbands?
Sahra: Oh yeah! And for women, a woman can help. The man, a man helps.

Sahra’s experience represents an issue unique to caring for adults, whereby
intimate tasks such as bathing are sexualized. Although Sahra notes that married couples may feel comfortable performing such ADLs across genders given that the intimate nature of the work fits within the mandates of a relationship, adult child-aging parent vertical relationships or paid caregiver-care-receiver dynamics preclude opposite sex physical care arrangements. The sexualization of male caregivers, in particular, resonates with the experiences of the males in this study (Prideaux 2010); they were often only assigned male home care clients and nursing home residents. It was a source of pride for some, then, when they found their care specifically requested by female patients, because they felt their skills were valued and stereotypes of male nurses as deviant, overlooked. While this dynamic did not appear to affect the distribution of transnational care practices given the difficulty of providing physical care in the form of bathing and dressing across borders, it reflects the perception that care responsibilities fell on everyone in the family – men and women alike – and did not prevent sons from taking on caring roles, before or after migration.

Also in a departure from perceptions of static “natural” gender differences, an interview with Darline and her partner, Stanley, reveals the possibility of evolving gender roles in Haiti where men are beginning to feel responsible for caregiving:
Darline: Back home, most of – when I was growing up – the ladies, they cook, they do the laundry, they iron clothes, and do stuff like that. And the men, some of them do, but back home, they like...
Stanley: I used to! (Stanley laughs)
Darline: Some of them did nothing. Some of them, they go to work. They work seven to seven, seven to four, eight to four; it depends. They bring money home. Now it’s different. Now it’s like in America; both work and bring money home. It's different.

Stanley’s reaction to Darline’s perception exhibits the general feelings and experiences of the men in this study. They felt they actively contributed to care when growing up and they continue to feel a great responsibility to provide for their aging relatives. While causal lines cannot be drawn regarding whether “caring males” are more inclined to enter the caring workforce, or exposure to the caring field makes males more attuned to caring for their families, evidence from the interviews suggest a mixture of both – not only did these men recall taking on caring tasks for their families prior to migration, but they also reported conditioning their transnational caring behaviors on what they have learned through immersion in the paid caregiving field which was often an occupational departure from the jobs they held prior to migrating. For example, Ricardo decided to sponsor his mother to migrate so he (along with his wife and sister) could care for her both physically and emotionally:

Ricardo: I gave her residence. I just filed for her, and they gave it to her. She was here last year. She was here for six months last year, but she went back
home. Now she’s coming back again, I think next month.
Megan: You and your sister that lives here will help?
Ricardo: Yeah. She lives in Milton, I live in Hyde Park. Not too far. When she comes and she’s living in my house, my sister comes in to help and my wife helps. I do that too, because I know how to do it.

Ultimately, Ricardo’s mother wants to retire in Haiti because she feels isolated in the United States given the hectic work schedules of Ricardo, his sister, and his wife. In the decision to encourage his mother to migrate and in the practice of caring for her when she lived with him, however, Ricardo felt his work experience gave him knowledge and expertise to provide both physical and emotional care. James tells a similar story:

James: We made that decision for her because I’m the only kid, so technically there’s nobody else to look after back there. Her mother is gone, so she’s just home by herself. It’s tough trying to take care of her when she’s back there. She just turned sixty-one a month ago. We figured out if she comes over here, she’s living with us. She’s an in-house babysitter, but she lives with us of course. When we’re not at home or when we go to work, we have someone to look after our kids. We don’t have to pay for a babysitter. Whatever she needs, we take care of her and her needs.
James: [She doesn’t need any assistance yet, but if she did] I think we’d do it at home; she’d stay home. From the experience that we have, my wife is a nurse too; so from the experience that we have, I think we’d be able to … we’d manage somehow. Of course it’s something you don’t want to think about right now, but it’s somewhere in the future, you know. I think I would do my best to take care of her, but depending on her needs, probably we would have somebody else come in as well, you can’t do it all. You can’t do it all.
Megan: Why would you like her to stay in the house; at home?
James: I think number one she gave her life to her own mother; she took care of her mother until her mother died. So I feel like, it would be like a payback to her. It’s probably cheaper too.
Being the only son of a single mother, James felt personally responsible to manage her care. While he was growing up, he watched and assisted his mother in caring for her parents, and he felt obligated to provide the same level of care for her: to “pay her back” for her efforts. Although James’ current situation is mutually beneficial in that his mother provides care for his children in exchange for residence, he initially suggested migration as a means to prepare for the day when she might need assistance with ADLs. James feels that because he and his wife are nurses, his mother will reap the benefits of their caregiving knowledge. Like Ricardo’s story, however, James anticipates that a paid caregiver might be necessary to accommodate for James and his wife’s busy work schedules.

Therefore while some female participants perceived an uneven distribution of caring responsibilities determined by gender and viewed themselves as the sole care managers for their family members abroad, most of the participants recognized feelings of familial obligation as transcending gender lines. Additionally, reports of actual caring practices did not differ among women and men in this study, as both genders noted the importance of

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21 James’ case indicates that transnational caring processes are not always strictly unilateral, but rather dynamic across the life course. See Baldassar for more information on the utility of mapping migration onto family lifecycles in order to “highlight the relationship between transnational mobility and communication and the ‘economies of kinship’, where migratory moves and long-distance connections are not always rational economic decisions but are often motivated by the need to give or receive care” (2007:294).
transnational contact, the desire for improved healthcare in the countries of origin, and their unique abilities and efforts to ensure holistic care for their family members.

IGNORANCE, GREED, OR “GETTING THERE”: HOW EVALUATIONS OF STATES DETERMINE TRANSNATIONAL CARE PRACTICES

When respondents felt immense personal responsibility to care for their aging relatives, they sought to provide services that they perceived to be unavailable, inadequate, or too expensive in the countries of origin. To fill the void in care, then, they initiated remittance activity and developed thoughtful plans to address such resource deficits. While these caregivers all engaged in a variety of care delivery from sending economic remittances or sharing medical knowledge directly with family members, working with non-governmental institutions and churches to improve access to care, or drawing up plans to develop or improve geriatric medical facilities, the decision on exactly which route to take was largely dependent on the participant’s view of the government in the country of origin. In other words, if caregivers believed the government “intentionally ignored” issues of the aging population, they were more likely to focus on assisting their aging relatives from the “bottom-up” by sending
remittances directly to family members or encouraging aging family members to migrate. When caregivers perceived governments to be largely unaware of elder issues, they envisioned large-scale change as being possible and suggested plans to transform care climates from the “top down” through the implementation of caring facilities, medical instrument businesses, and training programs for the broader community. Finally, caregivers who detected progress in aging issues by the sending country’s government focused their attention on intervening in the medical systems and facilities directly – an area which was viewed as needing significant work to meet geriatric needs. Assessments of political climates and perceptions of whether governments had the ability to transform played a significant role in shaping whether caregivers decided to work through the system or around it to improve the health and wellbeing of aging populations. To be sure, the economic and social capital of individuals also shaped the care practices of individuals; nationality was not necessarily a causal factor affecting the type of care practiced. The following case studies of Haitian caregivers, Jamaican and Honduran caregivers, and caregivers from the African countries of Cameroon, Kenya and Ghana are presented to elucidate general themes and common patterns of remittance activity for caregivers from these
regions. These practices are founded on perceptions, whether or not they reflect the actual political climate and existence of aging policies in each of the countries.

“They don’t take care of people. They just take care of their pockets”: Helping Haitians Receive Quality Care in the Face of Government Greed

Edouard was not alone in his scathing critique of the Haitian government when discussing the state of eldercare and perceived lack of policies to specifically address “the deserving elderly.” Indeed, the Haitian subset of participants seemed the most disillusioned in their evaluations of Haiti’s lack of government assistance in both wealth redistribution and the establishment of affordable and accessible public healthcare services. Not only did several participants indicate that Haiti has a struggling economy but many laid blame on what they considered “corrupt” and “uncaring” actors within the government. Mirlande, a HHA at an assisted living facility, echoed this point: “They care about their pocket, their family, but they don’t care about you. And they don’t have an institution where you can go to ask for help. They don’t have that. They don’t. I don’t see that many kids living on the street anyway in the United States.

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22 Given the small subsample sizes of African caregivers in comparison to the Haitian subset and the prevalence of commonalities between responses from caregivers across the African continent, narratives from Kenya, Ghana, Nigeria, and Cameroon were consolidated to provide analytical clarity.
They don’t. But in Haiti, the kids on the street asking for pennies, dirty, barefoot, you know, so that’s miserable. “Both Edouard and Mirlande lamented the lack of government pathways to help it dependent citizens.

With anger in her voice, Nathalie also questioned the lack of government assistance in Haiti, especially after she perceived a greater presence of international aid after the earthquake: “They don’t care about anything. They don’t give help for nothing. They don’t care for children, for old people, for nothing! I don’t know what they do with the money they send to Haiti for people for the earthquake. I don’t know what they do with that money. They just keep the money for their pocket. That’s it.” Even though many participants acknowledged that the U.S. has a stronger economy in the global system, the threat of additional corruption loomed large in the case of Haiti.

Stephanie questioned why Haiti has not followed the example of other countries, even those with perceived similar levels of development:

Stephanie: They don’t care about the old people. They don’t care. They don’t support them. We have the hospital, but – it’s really different.
Megan: What recommendations would you give to them to improve?
Stephanie: To change! (Stephanie laughs) To look to another country. To make it different. To take care of them. To respect people. To see how they’re supposed to do it. Because we have a lot of examples. My neighbor country, Santo Domingo, is really different from my country. But they’re very close. When you go to my country and you go to Santo Domingo, it’s very different. If they’re very close, why don’t they look like the same thing?
Megan: So does Santo Domingo have more services for the elderly?
Stephanie: Yeah more services, and the country was clean. The garbage...Santo Domingo is like USA. They really, really take care - They’re really nice. Why are they different? You know?

Despite Stephanie’s suggestions for the Haitian government to practice a form of institutional isomorphism, few of the respondents felt they could actually articulate change through government channels. Several participants provided blanket statements that “The President doesn’t care about the people” (Nathalie), “they just keep the money in their pockets” (Rachelle, Edouard) – statements that were evident in some of the interviews with Dominican respondents (Claudia, Renata) as well. The relationship between wealth and quality of care and the lack of government aid were common themes throughout almost all of the interviews with Haitian participants and seemed to enhance feelings of personal responsibility towards care, particularly through the means of sending remittances, training family members in healthcare, and encouraging family members to migrate to the United States.

Despite their feelings of antipathy towards the government, Haitian caregivers occasionally utilized institutions they found trustworthy and helpful such as churches to distribute remittances to the broader community. Samantha describes sending economic and in-kind remittances to her church in Haiti and
knows other Haitian congregants of her church in Boston who do the same:

Megan: If you can tell the government of Haiti to change, what would you say to them?
Samantha: I can’t tell them. No. They’ll do nothing. If you can individually, you can help, but no the government does nothing. But at church every month, I send money. I send money to give people food. Yeah. Sometimes, I make a box with shoes, dresses, and I send it there to the church. I do this by myself but I know people in my church in Boston, do the same. If you got money, yeah, you are going to help a lot of people.

Indeed, immigrants often utilize their churches in the countries of origin and co-ethnic churches in the Greater Boston area to help achieve their goals of “giving back” to their communities (Konczal and Stepick 2007; Levitt 2007; Menjívar 2007; Waters 1999). In situations where family members were not available to perform ADLs, participants often cited the role of churches in organizing care, managing remittances, and running nursing homes. Nathalie described how she used the church as a liaison to help other people in need, in addition to managing care for her own family:

Nathalie: Who cares for them? Nobody. Sometimes when I go to Haiti to visit my family some people come to my house. They say, “Nathalie, what do you have for me? Give me something; I’m hungry. I’m coming to see you if you have something to give me.” Some of them are my family members, some of them I don’t know. I say, “Okay. Here. Take that.”
Megan: So, you have responsibility for even more people outside of your family?
Nathalie: They need that, they’re hungry. Sometimes before I go, I send big boxes with food. I send them spaghetti. I send them rice. I send them vegetables. When they come to my mother’s house to see me I say, “Okay here.
That’s what I have.” I give them some shoes or clothes. They need it. I have the church, too, close to my house. The priests, sometimes I send something to them for the people, like a donation. Sometimes if I have money, I make the box with clothes, shoes, and food. I send that to Haiti. I say, “Give that to the priest. Distribute these to the people for donation.” I do that sometimes. Sometimes the priest calls me and says, “Nathalie, I pray for you. I pray for you a lot. I pray, pray, pray for you.” I say, “Okay.” They need that. They don’t have any President. No, they don’t care about the people.

Nathalie relies on the church to help her “give back” to people who need care. She feels obligated to provide for her neighbors by supplying them with food and clothes to give them nourishment and dignity because she feels the government has abandoned them (Agius Vallejo and Lee 2009). Churches were viewed as a safe channel that enabled them to foster and maintain ties with Haiti and affect change in ways they felt they could not through organized political action.

_Eldercare-Specific Remittances: “You will save people here; you will save people back home.” – Judeline._

Through their work with clients in the Greater Boston area, participants in this study discovered medical equipment that was essential to assisting elders’ mobility. Armed with this knowledge, caregivers often tried to find the means to provide their aging relatives with equivalent equipment. A caregiver from Haiti, Farah, noted that in addition to money, she sent a walker to help aging relatives
preserve their independence and quality of life:

Farah: Now it’s very difficult for him to walk. Last time I tried to buy a walker for him to send to Haiti. It’s not the same thing when he used to walk and now he can’t, so it’s not good.
Megan: So you send supplies down from here – like a walker from here?
Farah: Yes.
Megan: Are there walkers available in Haiti?
Farah: They’re expensive.

Farah discovered large cost differentials in equipment available in the U.S. versus Haiti. Many other Haitian caregivers expressed the desire to send different types of equipment to Haiti that they viewed as useful for their American-based care-recipients. In a similar quandary to Farah, Judeline feels that her mother must remain in the United States because she would not be able to walk without a walker:

Judeline: It’s really difficult for her to live in Haiti because she has a walker she can’t walk. That means Haiti is not for her. They need to have a lot of money to keep her to live in Haiti. She’s going to need a car for transportation, otherwise she won’t be able to go out. After the earthquake the streets you cannot even walk with a walker.

Even if Judeline wanted to send a walker, she feels the roads are too dangerous for her frail mother to navigate. Like Judeline, Jenniflore imagines the benefits oxygen tanks would provide her aging relatives, though her idea has yet to materialize.

Wideline, a Haitian caregiver at a Continuing Care Retirement
Community, also explained how she sent remittances designed to improve the quality of life for her aging relatives. So, in addition to keeping emotional contact through transnational communication and “carry[ing] [or sending] big barrels to the community with clothes, food, and whatever that they’ll share with each other” she provides her siblings with money earmarked for specific items related to taking care of her aging relatives. When asked who took care of her grandparents Wideline explains, “You do; plus your money, because you are the one who organizes and who called in the care. So you’ll say, ‘So and so, do the laundry. So and so, use this for medication.’ You make sure you call them on a regular basis to find out what they doing, what their needs are, what needs to be done, or what’s the future.” In managing care for her family members and providing for them materially and financially, Wideline attempts to provide holistic care from abroad.

In addition to providing direct remittances, Wideline has also formed a group with her cousin who is a physician in Haiti. Their goal is to make healthcare more accessible and provide options reminiscent to home care. She explains:

Wideline: Because we don’t...the government doesn’t get involved in the care...in the healthcare system in Haiti. Your health depends on the family; the more money you have, the better care you have. If you don’t have anything, you are
doomed. That’s why I have a group to work with … I am having a meeting to implement the system, to see who could work with it because I have my cousin who is a doctor and he wants everybody to pitch in to start developing this kind of system…a caregiving system, the same thing as here. They can stay in their house with their family and we will try to have some activities inside … and coordinate care.

Working around the ineffectual government, she feels that a transnational health network can improve the lives of senior citizens in Haiti.

...Many Haitian immigrant caregivers did not have the capital or means to send equipment or develop transnational health networks. Instead, they provided social remittances to their relatives in efforts to expand the knowledge-base of caregiving practices in their country of origin. Through receiving formal training for their positions as Home Health Aides and Certified Nursing Assistants, these participants learned of certain ways to facilitate lifting heavy clients, practicing CPR, and ensuring hygienic care to protect both themselves and their clients. When asked if by working in the caregiving field she had anything to offer to Haiti or the United States in terms of caregiving, Judeline responded:

Judeline: Yes, we do. Now if I go to Haiti I always tell people to wash your hands when you blow their nose. We did CPR because a lot of people end up dying without CPR. We could have saved that person’s life but nobody knew how to do it. You will save people here you will save people back home.

Despite her expressed desire to raise the standard of caregiving in Haiti, Judeline
was careful to point out that she taught caregivers for their own health and benefit, not because she saw herself as any “better” because she learned techniques in the United States:

Judeline: When I go there I say, “I’m not going to tell you that because I come from America, but it’s for your own good. It’s for your health.” Sometimes they say, “Who do you think you are – coming here from America to say that?” I say, “No. I’m teaching you something that’s going to be good for you. The same way I benefited, I came to help you with that.”

By virtue of working in the field of eldercare, participants have trained eyes to recognize health problems among elderly relatives and fictive kin. For example when Rachelle visited her godmother in Haiti, she intervened and acted as an agent of care for the woman whose own daughter could neither afford nor recognize the need for medical treatment:

Rachelle: Yes. She’s 93. When I went there it was like after Christmas; I went to see her. She was sick. I think if I’m not there she will pass away. The way I saw her, I took her immediately to a doctor. I have to buy medicine for her and I give her money to eat, to buy food, and yesterday I sent some money.

Cassandra also provided her mother with medical advice when she heard her mother’s recognizable symptoms. She recalls, “That’s why I always, I told her to put like chews or something to eat near her bed because the last time she told me her, not the blood sugar, maybe the blood sugar was down. She could not get up she was sweating and shaking. So it is not easy.” To these caregivers, then, a
main focus of their transnational caregiving efforts is to provide their family members and communities with essential health information and helpful medical technologies. Their experience in geriatric care allows them to recognize the resource deficit in skilled physical healthcare in Haiti. Guided by feelings of personal responsibility to provide care in the face of government neglect, these caregivers attempt to fill the void of medical care by sending earmarked remittances, transporting eldercare mobility equipment, and training informal caregivers in the technical delivery of physical care.

*Sponsoring aging parents to migrate or encouraging them to remain in the United States.*

An unexpected form of managing transnational eldercare and an important finding in regards to current comprehensive immigration reform debates, involved sponsorship of aging relatives to facilitate their migration to the United States.\(^23\) When Haitian caregivers felt that none of the

\(^{23}\) While I did not inquire about the legal status of the immigrants, many perceived that sponsorship of family members was an attainable goal. The United States offers *jus soli*-based citizenship, or membership determined by birth or naturalization, which posits the idea that rights and privileges are available to immigrants through family reunification or those who meet certain criteria of occupational merit (Koopmans and Statham 1999). The Hart-Celler Act of 1965 removed overt racially restrictive national origins quotas to help usher in the myth of America as a welcoming multi-cultural regime. Despite the shift to merit-based and family migration, ethnic minorities continue to be disproportionately affected by immigration policy and negative contexts of reception from the national to the local level (Kibria, Bowman and O’Leary 2014). Because of the perceived opportunity to sponsor family members through reunification,
aforementioned methods of care could help their aging relatives, they often resorted to sponsoring the migration of aging relatives as seen in Ricardo’s narrative earlier in the chapter. As of March 2013, family members can still apply for visas for parents through family reunification. Although this form of care involved removing elders from the sending country, or in the cases of aging parents already present in the United States, resisting sending parents back to the home country, the conscious removal of elders has implications for the governments of both sending and receiving countries, creating new questions about how to ensure social protections for the aged (Kilkey and Merla 2014; Levitt et al. 2015). Participants typically brought their parents to join them in Boston so that they would be able to care for them and receive what they perceived as better medical care. Stephanie, a Haitian caregiver, expressed her wish for her mother to migrate for medical treatment:

Megan: So you said you’re trying to have your mother be able to come here? Stephanie: Yes. I’m going to send her to the embassy next month, like April. After, I will try the best. Because I want her to be able to come here because if she comes here she’ll be able to go to the hospital. Yeah, because she has high blood pressure, and she’s diabetic. Everything; I take care of things for her. Megan: So would she stay with you or would she - Stephanie: Yes, she’d stay with me when she’s going to come. Megan: So it would be your job to care for her at that point?

however, these immigrants tend to focus on the merits of the system rather than its dysfunctions. They recognize the long process of acquiring visas, but note the end makes the means worth it.
Stephanie: Yes. My sister would live here too, but I think if she comes she’s going to live with me, my mom.

In other cases such as Fabiola who was also from Haiti, sponsoring her mother not only ensured that she would be able to care for her mother, but that her mother would also be around to help her manage care for her children so she could go back to school to pursue higher degrees in nursing.

Edouard, a Haitian male, also noted differences between the medical care available to his mother and services available to his mother who had migrated to the U.S. after his sister and brother arrived. Although he praised the services available for his elderly mother and noted his sister’s thankfulness that they were able to care for their mother in the U.S., Edouard experienced the restrictive arm of the government in regards to immigration:

Edouard: My mother, she died in 2002 in Boston. She came to U.S. in 1999 or 2000 and after two or three years she died. I could not come to her funeral because at that time I didn’t have the visa to come to the U.S. At that time I went to the consulate to ask them for a visa. My sister and my brother had sent me paper that my mother had died in U.S. and I wanted to assist in the funeral. But at that time I didn’t have a job, I didn’t have a job in Haiti and that is why I think they didn’t give me visa to come to U.S. Yes, my mother was very happy when she went to see the doctor. It is not the same in her country. In the U.S. they take care of them; it’s a modern country. My sister said that she was really happy when she went to the hospital. People took care of her and she was happy for that. And she stayed with them. I think she stayed in the hospital after her heart surgery. They kept her alive for six months in the hospital. There she was looked after until she died.
The perception that the U.S. government cares for the elderly, and that Massachusetts, specifically, provides accessibility to healthcare and other services, resonated with several of the participants, overshadowing restrictive policies towards the migrants, themselves. Having little faith in concrete improvements in healthcare or government-backed subsidies to help control costs of care, these caregivers felt their only resort was to have their families join them to receive medical care in the United States.

*The Medical Middle-Ground: Refining Geriatric Healthcare in Jamaica and Honduras*

Participants who migrated from Jamaica and Honduras offered less hostile views on government support in their countries of origin. Instead, they perceived some government financial assistance for citizens and promising but rudimentary state-funded programs to provide elders the opportunity to access nursing, rehabilitation services, and home care. Anita, a HHA from Honduras, attributes these changes to “Americanization”:

When I was there they didn’t know how to do much of it. Since I came up here everything changed. A lot of things are different; they changed up. The capital in my country is more Americanized they got most of the things up there; in the capital. Now they have nursing homes. I was talking to my sister and she said now they have Lifeline. But not everybody has it. If you could pay for it you have it. She thinks she has it. They didn’t have it before, but I know now they have rehab too. They didn’t have rehab and now they have rehab. The old people still don’t want to be in the rehab they want to go home. My daughter-in-law her mother is sick: she has diabetes. She has very bad diabetes. She was in
the hospital a few times and she came up. They were going to put her in a rehab and she said she wanted to go home. My daughter-in-law had to take her home because she wasn’t staying. She wanted her kids to be there.

Anita saw Honduras on a strong path towards providing options for skilled healthcare, but she noted the cultural aversion to receiving extended treatment in facilities prevented some senior citizens from utilizing such services. Lorena, another participant from Honduras, described the presence of publicly funded clinics. She notes: “They can see if you have some pain. If they need some operation though, they send you to the city.” When asked whether any programs like home care existed in Honduras, Lorena affirmed that “we have that” and that it was funded by the government. Her perception is consistent with Anita’s remark: “The government cares as much as they got to do. They care too.”

In contrast to the limited government services available in Haiti, two Jamaican respondents, a mother and daughter who migrated together, also appreciated the availability of home care, health insurance, and nursing homes in Jamaica, but preferred the practice of familial care, if available. Allison notes that Jamaica provides “lots of programs” including: “the nursing home. They have the health insurance. I think I heard there’s a food program also. Yes, and medication. It’s a small country so I guess they do the best they can with what
they have, they do.” Allison also remarked that she heard from “other sources” that Jamaica now has home care services, as well. Beverly, Allison’s sixty-three year old mother, found nursing homes in Jamaica to be a viable, but not favorable option for elders with family that have died or migrated:

Beverly: How we do it, most of the time, is the girls will take turns and take care of their family; we don’t put them in nursing home, unless if it is like some people, like how I traveled here. And if I have my mother back home and there is no other family member to take care of her, they put them in a nursing home. Otherwise, if you are back home, we take turns at their care. I will take care one day, the other sister will take care another, and that’s how. But we don’t really put them in nursing home, if we are there. But if you travel and you don’t have any close family who could do that you put them in nursing home. Sometimes you believe that, yes family member is the best, to take care.

Like Anita, Beverly views institutional care as a last resort for eldercare.

When engaging in remittance activity then, these participants from Honduras and Jamaica focused on addressing medical care directly – in ways similar to the eldercare-specific remittances performed by their Haitian counterparts. Rather than blaming the government, however, these caregivers bemoaned the perceived poor quality of medical care attributed to a lack of training at the institutional level. They were determined to intervene by providing equipment and advice related to skilled healthcare that they learned from their jobs in eldercare.

Grace, a Jamaican CNA and HHA working at a continuing care retirement
community, reflects on her father’s experience of vulnerability when she saw him lying naked on a hospital bed in Jamaica. She makes sure her clients are never in the same helpless position:

Grace: Yes, because when I heard he was sick and I went to the hospital down there I’ve never seen such ... being in the medical field, and caring for people I’ve seen some things, but in that hospital I’ve seen things I’ve never seen before. How can a patient be sick in the hospital? They said he had a high fever. How can you have him naked in the hospital not even wearing pajamas? And that place is cold! Naked. And I brought pajamas for him and they said no because he has such a high fever that he has to stay naked. I think that would lessen his dignity. They did not preserve his dignity, and I thought that was a shame because I’ve seen people here with a high fever and they have clothes on. You don’t put a patient naked in their bed. Oh my God, I couldn’t believe that! I couldn’t believe how he was exposed. I said, “What is the reason for that? He has no clothes on, just a sheet over him?” “He has a high fever.” I said, “That doesn’t mean anything, you don’t keep people without clothes because he has a high fever, you have other ways: push cold fluid, do this, do that, you can...” Oh my God, they didn’t want to hear that! They didn’t want to listen to me, but I think that’s...and that was not...a person has a right to privacy. A person has a right to dignity even in death; people have a right to dignity and privacy. How can you keep somebody without clothes on? I’ve never seen that before.

Grace had spent several years as a CNA by the time she visited her father in Jamaica. She interpreted the scene through a transnational lens that informed her of alternate ways to tend to sick patients that did not involve stripping them of their clothes and ultimately, their pride. To Grace, the hospital staff’s refusal to clothe her father lessened his self-worth and lowered his quality of life.

These participants also provided medical supplies that they felt would
enable home care, so that aging relatives could remain comfortable in their own homes surrounded by family, while still having access to necessary medical technologies. Anita elaborates:

Anita: Yes, they send money back. They always do that. They have a nice place for them in the house. They take good care of the old people and they take a wheelchair sometimes from here. Sometimes they are sending walkers. Now they have walkers over there. Now they send walkers for them and pull ups. They send them to them down there. My aunt was sick there and her grandkids used to send the wheelchair and everything for her and the pull ups – everything that she needed that they had up here and they couldn’t get it down there.

In her work with her clients, Anita also saw the usefulness of an emergency alert system called Lifeline™. Lifeline™ allows senior citizens to press a button to receive emergency medical and ambulatory services. Anita reported that Lifeline™ was especially important for her clients that did not have 24-hour care. She passed this knowledge on to her brother who was having trouble lifting his wife when she fell: “I told them to get the Lifeline. Lifeline is good. All she would do is call and they would come and pick her up. That would help you.”

Seeing the benefits for her clients, Anita also expressed how she wished Honduras would have similar services: “I wish more people over there had assisted Lifeline because they need them. And more access to walkers, wheelchairs – they need all of these stuff over there. The elderly people are very important over there. The young people respect them so much.” While she took
the first steps to send down mobility equipment, the Lifeline™ system is more
difficult to implement as it’s tied to local EMTs and hospitals. Unlike the Haitian
subset, these Honduran and Jamaican caregivers maintained optimism that
change could occur at the macro level as reflected by the newly formed programs
for geriatric care.

Out of the Shadows: Creating Awareness, Building Businesses, and Teaching Care in
Africa

Participants from Ghana, Kenya, Nigeria, and Cameroon describe “aging”
as a relatively new social issue for their countries that has yet to be addressed in
the political realm. Unlike the Haitian sample who perceived intentional malice
and corruption within the government, these African caregivers felt a lack of
advanced healthcare services for senior citizens and other dependent
populations reflected a lack of awareness about geriatric issues. James believes
people in Kenya are just starting to live longer and continued medical
advancements will extend the average life expectancy:

James: There are the regular hospitals. They are private owned hospitals. The
government owns some hospitals, some private companies own hospitals, some
non-profits also own hospitals. Long term care is usually done at home by your
own family. It’s been like that; I’ve never even heard of senior living facilities.
I’ve not even come across one; I can’t even think of one. Actually, that’s
interesting, I should go on Google and see if there’s anything out there in Kenya.
Just like you know here we have advanced directives. Over here we have
advance directives, like DNR, DNH and all that. You tell somebody in Kenya
that they’ll look at you like you’re crazy; they’ll be like, what the hell is that? Long term care facilities, I’ve never heard of any. Taking care of the elderly is done at home. You have to understand that people don’t live for long over there. Not like over here, people are hitting a hundred, a hundred and two and that’s nothing. In my country, my grandfather died, he was 76. My grandma was 82. That’s like super-old; that’s ancient! People don’t live for so long. Probably now, as time goes by, they will.

Because the growth of the “oldest old” population is a recently new phenomenon, African caregivers believe that lack of institutions, training, and government programs stem from ignorance rather than intent.24

Indeed, several of the African caregivers expressed experiencing revelations about care after working in the field in the United States. In determining how to provide care for their aging relatives, then, these caregivers felt the first step would be spreading awareness of aging issues to their countries of origin. Not only did these caregivers want to elucidate the public concerns that stem from a growing aging population, they also wanted to make sure that new caregiving initiatives were well informed and directed towards providing quality holistic health. For example, Nadine was interested in teaching eldercare training and healthy living to people in the future through establishing an information center:

24 The National Institute on Aging distinguishes between the old and the oldest old, “often defined as people age 85 and over. Because of chronic disease, the oldest old have the highest population levels of disability that require long-term care. They consume public resources disproportionately as well” (U.S. Department of Health and Human Services 2015).
Megan: What do you envision your life to look like in twenty years?
Nadine: In twenty years, I hope I will be back home. I want to open a center where I train people in home health. I would train them to eat healthy and how to take care of aging people. Yes, like a training, awareness, like an information center, where I tell people about all those matters that I hear about how to take care, how to help. Because there are some churches in Cameroon who try to help. Like when some people are mad, they just abandon them in the street. So the sisters are going to take them, give them shelter, or even bury them. You know they shouldn’t be the only ones to do that. Other people should also.
Megan: That’s interesting. So what would be your first lesson?
Nadine: How important caring is, you know. And now we are doing it for them, but pretty soon, somebody has to do it for us too. Because they’re old now, maybe too they’re going to be old, like them. Yes, I would like to do that. I like to care for people, to help.

At the end of the interview Nadine reported that she has been “inspired a lot. You know, working here, taking care of the elderly.” While throughout the interview she noted the strong communal ties between families in Cameroon, she perceived the need for trained caregivers, especially for elders who had been abandoned due to mental illness. Although she recognized the role of churches in assisting abandoned elders, Nadine noted that “that is an aspect that I think in my country we really need to raise people’s awareness of that. Because the aging population is like abandoned.” She has started writing lessons on caregiving and healthy living to implement in Cameroon once she gets to retirement.

Myra’s exposure to skilled caregiving also transformed her perspective on care in Cameroon:
Myra: I would like to do something in Cameroon – maybe help some of the hospitals. See what I can do for them and send some equipment if I can help them buy some. Take care of patients in the hospital. If there could be a facility one day where maybe the elderly... if they don’t have any children or you don’t have anybody who can take care of you...Maybe start like a group home. I think my work here has taught me a lot. If I go back to Cameroon I don’t think I would look at things the same way I use to. I appreciate working here and caring for the residents here. I have learned a lot.

Wanting to “give back” to her community, Myra plans to work with hospitals in Cameroon or develop her own institution to provide care for senior citizens “without family.” James tells a similar story about a Kenyan colleague of his:

James: Recently, there’s actually somebody from my country who just started a program. She’s a brand new nurse. She’s probably done that job for about a year, I would think, but she’s asking for donations like blood pressure cuffs, stethoscopes, medical supplies. She’s willing to pay money to ship them over for people to be using them to take care of other people, meaning creating awareness at the same time. It’s somebody who has that passion from here and they’ve seen how people have suffered over there.

James believes this transnational caring activity both creates awareness and has the practical value of bettering healthcare in Kenya with the infusion of supplies.

He builds on this idea in his own plans for transnational caregiving:

James: I’m hoping that I’ll be able to open a business in my country, health related. My biggest interest has been medical imaging, equipments and business because I don’t think that will ever go down. I’m hoping at least, to have started off something that is going to make a difference in somebody’s life in the future. I don’t have something exactly, but just something, not that it’s going to be tied to my name, but something I can … somebody can look back and say so and so was so thoughtful they started this; it has helped so many people. Like it’s about giving back, giving back to the community.
The narrative of “giving back” to the community as a whole was particularly prevalent in interviews with African caregivers. This group-orientation shaped their transnational caring practices and plans in significant ways. It guided them to makes plans for businesses in the case of James and Myra, or to develop non-profit organizations in the country of origin, as Kwesi’s story indicates:

Kwesi: Old age? (Kwesi laughs) Probably I would say in Ghana, to also inspire the people in the community that I found myself in, that if I have done it, everybody else could do it. At the moment, my wife and I, we have a nonprofit organization, it’s a charity organization that is a school where I started my kindergarten. We care for them, we send scholarships to the school, help with tuition, we send books; we send computers, sports equipment, and things like that. We sent some money recently to do renovation of the school, painted the school – it’s very nice. We try to give back to our community. Not necessarily in Africa. We’re also trying to help out with here in the U.S. Megan: What inspired you to do all of that? Kwesi: Again, by my nature, I’m a person that always has vision, a visionary comes to mind, and I always want to make an impact to better other people’s lives, and create awareness especially coming from a different culture here. It’s very important to let other people know that you are not on a threat, that you are here to help the city. I worked in the City Mayor’s office and I also volunteer at the Mayor’s office. I get involved in the city and the way things are.

In a departure from accounts rebuking the state in the Haitian case study, Kwesi sees the value in working with government forces at all levels to affect change. By focusing on developing new institutions, organizations, and partnerships these caregivers approach changing the care climate from the top down.
In some cases, participants called on the United States to assist other “less developed” countries in establishing accessible healthcare and social insurance programs. Their transnational identities and behaviors encouraged immigrants to view countries as pieces of an interconnected global puzzle rather than isolated entities. James feels that although Kenya has a wealth of social and cultural capital to build a strong foundation for institutionalized eldercare, he perceives financial capital as ultimately necessary for advancements in healthcare:

I want to see the United States government chip in and say hey, look, maybe we can build elderly homes in ... we can help out a few governments fund them a certain percentage, as long as we can see productivity of it, we can see the good use of it. I think everything comes down to money, unfortunately.

Daniel, a middle-aged Haitian male who worked as a CNA for years prior to his appointment to union leadership, also reflects on this global imbalance and the consequences for eldercare services:

I think... in regards to Haiti, we should have a better system for how... if the country is on the side of improvement, development, if we want to treat elderly better, we should provide for their needs. Let’s say you have a broken hip or something happens, will that person be able to get a walker to walk around? Will that person be able to get a wheelchair to get around? All these things have become a big issue but I think the U.S. as a whole needs to work with those poor countries to improve the care, the healthcare of this country. On the other hand, on the flip side, those countries they need to help themselves too. They need to
put a plan in place for what are they going to do for people when you get... when you become eighty years, or when you become like ninety years old. Haiti and the U.S. are totally different countries; you cannot expect what happens here to be happening in Haiti.

Despite having vastly different biographies and migration histories, James and Daniel articulate similar perceptions of how the U.S. government could assist Kenya and Haiti in the acquisition of medical technology and services. However, to them, pure philanthropy or reparations are incomplete solutions.

Themes of neoliberalism resonate throughout their stories and the responses of many other participants. Given the prominence of neoliberal strategies in government policies worldwide over the past century, especially since the global interest rate increased dramatically by the end of the 1970s and developing countries were forced to acquire loans and submit to Bretton Woods-designed Structural Adjustment Programs to service the previous loans they obtained for development, it is unsurprising that the collective habitus of immigrants would be shaped by ideas promoting market deregulation, retrenchment of social welfare, and personal responsibility (Babb 2005; Fourcade-Gourinchas and Babb 2002; McMichael 2006; Misra, Woodring, and Merz 2006).

An environment of privatization and increased inequality accompanied by escalating distrust in the capabilities of governments to provide for the people
are only compounded by the prevailing myth of the American Dream that works to shape the neoliberal perceptions of these immigrants. As a result, these immigrants feel a strong sense of personal responsibility to not only excel at their job in the U.S. but also to provide services for their aging relatives abroad who depend on their remittances in place of government assistance.

In addition to traditional forms of transnational care such as the oft discussed money transfers and material remittances such as clothes and food, the respondents revealed several other forms of transnational eldercare that change the climate of eldercare in both sending and receiving countries. While all the respondents participated in some form of transnational care or contact through communication or sending remittances, these respondents also suggested unique forms of transnational care specific to bettering the lives of elderly relatives living in the countries of origin. These care practices include sending specific equipment designed to facilitate elder mobility; training and teaching informal caregivers about hygiene and CPR when visiting or planning to establish training centers for home health aides in their sending countries; and at the most extreme, sponsoring aging family members to migrate to the United States in order for the relative to have care and access to better medical facilities.
CHAPTER FIVE: Filling the Emotional Void: Delivering Dignity to Clients in Boston

Before the seminal works on nursing home care by Timothy Diamond (1992) and Nancy Foner (1994) in the early nineties, few sociologists recognized the value of understanding paid caregivers’ perspectives on eldercare. News stories carried sensational accounts of nursing home abuses; among them bed sores from neglect and in some cases physical and sexual abuse – that America’s vulnerable senior citizen population received at the hands of perceived untrained or uncaring nurses’ aides (Foner 1994; Vladeck and Feuerberg 1995). Along with a real and growing demand for paid care, these troubling accounts motivated scholars like Foner and Diamond, and more recently, Rodriguez (2014), to investigate eldercare institutions through a qualitative lens. Their goal was not only to observe the quality of life in nursing homes for the residents, but also to understand the physical and emotional work from the perspectives of the caregivers; to illuminate the backstories behind the faceless villains portrayed in the media.

With the commodification of care increasingly accessible to varied socioeconomic classes and often deemed necessary due to the prevalence of dual
earner households, more sociologists have turned attention to the work and workers involved in paid caregiving. Scholars such as Hochschild (2003), Ibarra (2010), and Stacey (2011) have noted the importance of emotion work to clients’ wellbeing, whereby caregivers emphasize the values of listening, talking, emoting and nurturing, among other relational aspects, as a central part of the job. While demonstrated emotions practiced in congruence with the “feeling rules” of a situation are learned skills, these emotions and bonds may very well align with actual and authentic emotions felt by the caregiver (Rodriguez 2014). And although the bonds caregivers develop with their clients can be valued and appreciated by clients and their families, too often emotion work is often dismissed as “natural” and “not a real job,” providing fodder for groups against unionization and increased wages and benefits for direct care workers (as will be discussed in the concluding chapter).

Indeed, with such an entrenched, taken-for-granted rhetoric of carework as personalistic, the caregivers in this study often highlight emotion work as the most important aspect of their jobs. The transnational orientation of these immigrant workers also helps to accentuate the idea that building emotional bonds is central to improving the lives of American senior citizens. Thus, while these women and men reevaluate care for their families in light of the direct care
training and increased awareness of United States age-based welfare programs and medical advancements brought about by their jobs, they also reflect on past caregiving experiences in their countries of origin while they tend to their American-based clients. As mentioned in Chapter Three, many of the participants recognize that senior citizens in the United States receive a wealth of financial and medical benefits from the government – a government they perceive as having the economic means and democratic support to provide such welfare. Where these immigrant caregivers find quality of life for American seniors to be lacking is in the minimal familial presence and accompanying emotional support available to elders on a day-to-day basis. By filling this void, these caregivers feel they are “saving” the clients by being available to keep an eye on not only the physical care, but also the emotional wellbeing of their clients.

This chapter explores the emotional and physical labor caregivers perform in their work with American-based clients. It illustrates how caregivers view their relationships with clients and how they define emotional labor as providing kindness, patience, dignity and respect for the clients. Given that emotional labor often holds precedence in their hierarchy of caregiving tasks, traditional relationship-building seemed more feasible for workers in home settings than for
workers in nursing homes. This is partly due to understaffing and decreased autonomy from higher-level staff, both common problems at the nursing facilities. Since many of the participants had experience in both home and institutional settings, whether holding jobs in both, moving between jobs, or having had clinical practice for home health aide training in institutional settings, they were able to speak to how caring context impacts their job performance differently. Findings reveal that despite these time constraints, caregivers in institutions interpret activities that may be commonly associated with physical ADLs as bodily tasks essentially infused with love that evoke very real emotional consequences for the client. Therefore their definition of emotion work highlights the intricate methods of touch and the intimacy of cleaning the clients as mattering greatly for preserving the client’s sense of dignity. This emphasis on achieving emotional benefits through both relational and physical labor corresponds to their goal of providing the missing piece to achieve holistic healthcare for elders in the United States.
FILLING IN AS FICTIVE KIN: DETERMINING CARE RESPONSIBILITIES FOR CLIENTS

“Some of them, you don’t even know if they have family until they die.”

- Darline, CNA, Haiti

Chapter Three illustrated how immigrant caregivers perceive the state of eldercare around the world and how they conceive of their particular roles in improving the care climate. Universally, the participants in this study feel that elders need a combination of physical presence to assist with ADLs coupled with emotional connection. While the state’s funding structure and established care practices ensured rigorous medical care, these participants find that senior citizens are missing a sense of “connection.” As these caregivers spend time in the U.S. and both observe and experience firsthand the pressures of the economy on the ability of family members to care for their aging relatives, many alter their perspectives from viewing American culture as emotionally deficient to recognizing the work-family time crunch as a major factor contributing to the growth of non-familial care. To be sure, many of the participants noted that clients’ families would visit “as much as they could” given time and distance pressures. Regardless of the perceived cause of elder abandonment, however, these caregivers felt that many of their clients were lonely and that their presence
as caregivers was both helpful and necessary.

When asked what she felt was the most important part of her job, Allison, HHA and homemaker from Jamaica responded simply, “That I’m making a difference with them.” When prompted to describe how she feels she makes a difference, she continued, “I help them with whatever they need then and make them feel happy. Sometimes they’re sad. They just need someone to talk with them and keep them company.” Allison, like many other participants in this study, emphasized emotion work and specifically, combatting the chronic problem of loneliness by being at hand for her client’s emotional needs, as a major facet of her work as a caregiver. This visibility of clients’ loneliness transcended the care context, with caregivers in both home settings and institutions recognizing the value their presence served. Wideline, a Haitian immigrant with CNA and HHA credentials working in the Assisted Living Facility of a Continuing Care Community, responded similarly to Allison when asked the same question:

Megan: What would you describe as the most important task of your job?
Wideline: Your relationship with the client. Sometimes they are lonely and they need someone to talk to. And if you make time or focus more to listen to them, even they don’t ... even if you don’t agree with what they are saying but you listen and I’m a good listener.
Megan: Have you had any difficult clients to deal with?
Wideline: Oh my God, yes, I do. I do, but at the end of the day, I become their best friend. Oh, yeah.

Both Allison and Wideline emphasize the essential role of listening in their work as caregivers. Whether or not they enjoy the dialogue is somewhat irrelevant to these caregivers; they articulate that the emotion work of making the client feel as though s/he is heard is an important skill and quality that makes them good caregivers.

Emotion work such as listening, engaging in dialogue, and nurturing take on greater importance when these caregivers contrast the perceived loneliness of American elders with ideas of communal care and ever-present familial support in the countries of origin. While Claudia, a home health aide from the Dominican Republic, recognizes that her job involves homemaking tasks such as cleaning, she emphasizes her client’s feelings as needing the most attention:

Claudia: I feel that, thinking about the feelings of a person. My job there is to clean, my job is to talk and speak with her, and “How do you feel? Do you need something?” You know, the feeling is so important, because the elderly people in this country live alone. They mostly live alone, so their needs are to speak with another person, feel another person loves him or loves her.

When Claudia realized that one of her client’s did not have any children, she felt “responsibility” to fill the role she imagined a daughter would normally do for her mother:
Claudia: I feel like a daughter. Because I feel like a daughter; like for example, the woman I go to every morning, she lives alone. She doesn’t have children. So I feel like her daughter, so that’s important for me, because I feel the responsibility thinking about this kind of person.

The pressure she felt to provide emotional comfort to her client above all else was especially strong. Throughout the interview, Claudia frequently mentioned that she admired the financial, housing, and medical benefits available to senior citizens, but her “complaints [were] about the feelings” in this country. The reader may recall from Chapter Three that she also reflected on the increasing commodification of care by mentioning her fear that these “feeling problems” she witnessed in the U.S. are spreading around the world, with fewer people available or interested in providing care for their families. Her sense of self was directly related to preserving that missing piece of emotional comfort for her clients.

*Fictive Kinship*

From CNAs to HHAs, these caregivers see their role as filling the gap of familial care to their clients. As Claudia’s response illustrates in the previous section, she takes on a fictive kinship role for her client, fulfilling the physical and emotional care that she normally associates with a daughter’s responsibilities. Claudia, and many other participants in this study, internalize
the “golden rule” of paid carework, whereby caregivers feel obligated to care for others as they would their own kin (Tuominen as cited in Dodson and Zincavage 2015). This family ideology resonates with the caregivers, and they often illustrate their bonds by using familial terms such as “Mama” and “Baby” when interacting with their clients. Several caregivers also cite their clients’ usage of familial terms towards them as evidence of the affection and strong connection they share. When asked how she would describe the relationship she has with her residents, Efie, a Ghanaian CNA in a nursing home answers: “Oh, I love them. I’m so attached to my resident, and then, I don’t know, some of them tell me, “Oh, I wish I could adopt you.” When I asked Yadira, a home health aide from the Dominican Republic who has only been in the United States for one year, the same question she responds:

Yadira: Good. They love me. They call me child. They call me baby.
Megan: How does that make you feel?
Yadira: Good, because I feel that they love me so that means that they can feel that I’m doing everything good to let them know that I feel comfortable working with them.

Yadira associates her client’s terms of endearment as an indication of their love and happiness with her service. She also employs emotion work to reassure the clients that she, too, is comfortable with this kin-like relationship, and therefore will be reliable as a caregiver on the same level as a family member. Benefiting
from a broad conceptualization of “the family” in their countries of origin, the practice of fictive kinship becomes seamless for the caregivers trying to establish bonds with their clients and patients in the United States.

A majority of the respondents mentioned patience and compassion as necessary skills needed to perform direct care. Viewing client care through the lens of fictive kinship made patience and compassion seem more important and vital to quality care. Caregivers report that using these techniques and treating their clients as family members makes them excel at their jobs and elicits favorable emotional responses from the clients. Lovelie, a Haitian home care worker with both home health and homemaking experience, explains how she desires to provide well-rounded care to her client as though he or she was one of her parents:

Lovelie: Usually when you’re working for a patient you have to be patient, love the person, and take good care of the person. Usually I do everything for the patient, like I feel like it’s one of my parents. I clean the house, take care of them, and make them feel good.

Madeline, another home health aide from Haiti, echoes this point, utilizing the family ideology in her relationships with clients:

Madeline: I like everybody. When I take care of somebody, I see my father, I see my mother, I see my son. I see my - I don’t know exactly…I take care of my clients the same as my family. They like me, I see that.
Madeline’s response evokes the notion of physical and emotional care as universally beneficial, regardless of the age of the recipient. She takes into account her emotions for her parents and son when she works with her elderly clients. Like the other respondents, Madeline attributes positive responses from her clients to her fictive kinship practices.

These immigrant caregivers derive their passion, drive, and pride in what they do from thinking about how they would care for their own parents and grandparents. When asked how she would describe the relationship she had with her two home care clients, Esther replied:

Esther: I think both of them, I give my affection with them like I would my mother... When my own mother had a stroke, I was in Port-au-Prince but she was in Provence. When I got there, I brought her nice clothes, I give her a shower, and I always have some good lotion in my bag. Make her smell good; she likes that. We stay outside for a while. She was so happy. And that’s why I like to do it for others – for elderly people, to make them comfortable, to make them happy, to have a long life.

Esther’s mother has since passed away, but she continues to reflect on the caring strategies that made her mother happy when she works with her clients in the United States. She feels that affection brings not only mental benefits but also very real physical benefits.

In many cases, absence from the country of origin and his/her aging relatives enhances a caregiver’s desire to create and maintain fictive kinship
bonds with clients. In a sense, caregivers negotiate their own abandonment from their parents overseas by projecting their physical and emotional care to their clients (Hochschild 2002). While discussing what makes him “good at his job,” and specifically citing his expertise at building relationships with his clients, Ricardo, a Certified Nursing Assistant from Haiti who has been living in the United States for about twenty-seven years, calls on his experiences caring for his mother and managing her care across borders:

Ricardo: Working with your heart, make them like your mother, your father. My mother is eighty-seven years old. She’s in my country. She’s in the wheelchair. She’s home, because my sister take good care of her. She was here before with me, and then she go back. She’s going back, because she doesn’t like it here. She’s 87 years old; she knows everything. She’s not walking, she’s in the wheelchair; she’s walking with the walker. That’s the way I feel. **When I take care of them in here, I feel my mother, even my father** who passed away six, seven years ago. I feel, I think of my father, I think of my mother. If you’re working with your heart, you’ll respect the residents; you treat them with the respect and with the privacy and then make them comfortable.

Ricardo praised the convenience of having his sister able to take care of his mother at home in Haiti, preventing the need for acquiring paid care, which would have been the circumstance had she stayed with him in Boston. In addition to Ricardo’s mother deciding to leave the U.S. because she felt isolated compared to her lifestyle in Haiti and trapped due to language barriers, Ricardo also encouraged his mother’s return. Recall from Chapter Three that Ricardo felt
that his hectic work schedule – he worked at two different skilled nursing facilities and often took on extra hours helping out in the assisted living branch of one of the CCRCs – prevented him from providing adequate family care for his mother. Ricardo and his wife felt that hiring paid care in the U.S. would be cost-prohibitive. As a result, Ricardo’s mother returned to Haiti and received physical and emotional care from his sister, while Ricardo sent money to his family to help pay for basic needs. Thus, likening his clients’ care to how he would want his mother to be cared for if he were able to provide such care in person, Ricardo holds himself to the highest standard.

For those caregivers who did not have family to rely on to care directly for their aging relatives, the sense of fictive kinship with their clients was especially strong and often mutually rewarding. After the 2010 earthquake in Haiti, Farah and her children came to the United States under Temporary Protected Status. Emotions ran high throughout Farah’s interview due to the freshness of such trauma, but only when she began to talk about seeing her clients as a reflection of her late mother, was she moved to tears:

Megan: In your opinion, what makes a person a good caregiver?
Farah: I think, you know, when you work in the nursing home, when you do home care, sometimes you are alone, you and your patient. I think you work with your conscience. It may be only you in the nursing home, but you lock the door, even God see you. You see, I never [took] care of my mother. Maybe
today, I have to do something for these people – what I was never able to do for my mother, I have to do that. I have to do that very nice. I never change my mother. Now this is my chance to do what I never do for my mother. I have to give that back to those people. That’s why, when I work with home care, with the nursing home [residents], I think about my mother. I am very nice, very patient with my residents.

Farah was a nurse in Haiti, but her credentials failed to transfer to the same level in the United States. Prior to the earthquake, she worked in the city, while her parents lived far away “in the mountains.” Since the cost of domestic work was affordable, she hired a maid to help her with “personal care: wash the clothes, feeding her, everything” for her mother. Now that she works in both home care and at a nursing home, Farah treats her residents the way she hopes her mother was treated in her absence. She offers her love and care to the clients as a way to “give back” what she failed to provide to her mother. Similar to Farah, Darline also employs a maid to help with her mother who she could not tend to by virtue of distance:

Darline (Haiti): Sometimes it’s not about the money. Sometimes it’s like passion. Sometimes it’s passion, like I told you, some of them, I can see, through them, my mother. She’s back home all alone. She has people who help her, but they’re not her relative or anything like this. When you’re helping someone and then you think about your mother or grandmother, it’s like passion involved. It’s not about the money. You don’t see the money.

Both Farah and Darline projected their own feelings of abandoning their mothers and conceptions of ideal care onto their clients. In some cases, responsibilities
associated with fictive kinship provoked feelings of pressure to go beyond what was called for in the job description. Rationalizing that the gratitude she receives from a client is more beneficial for her own psyche than the extra work involved, Darline continues:

Darline: Like you might have ten people, and someone would request that he or she wants you. Some people don’t do it, but because of that passion, and then it’s not because she’s your grandmother because I don’t have a White grandmother! (Darline laughs) I don’t have a White grandmother, but because of the passion and she makes you feel good about yourself when she’s telling you how sweet you are. She’s like, “Oh you’re helping me, you’re so soft.” I’m like, oh okay I want to do that every day.

Indeed, many of the caregivers report spending extra time off the clock with certain clients to provide emotional support and companionship. This is especially prevalent in the home setting, as will be discussed later in this chapter.

The emotional connection with clients can sometimes be so strong that it interferes with the caregiver’s time with his or her own biological family. These immigrant caregivers often feel pressure not only to take on multiple jobs to make ends meet to support their families in the U.S. and abroad, but also to go beyond the job description to fulfill extra tasks for their clients, eating away at free time. As Dodson and Zincavage note, “the family construct institutionalizes an expectation of self-sacrifice or of putting ‘adopted’ kin above all else” (2015:198). Thus, the client reaps the benefits of the family ideology with little
reciprocity for the caregiver and his or her biological family beyond the occasional identity benefits alluded to earlier:

Renata: It’s, for me, it’s easy because I like to take care of old people, you know? I feel like they are my family and I do the best thing that I can do for them. I have been working for the company like for three years and nobody ever called for any complaint. And not only that, when I have to go to my country because I’m missing my family over there – I enjoy my family back there and we can share and do many things together – [the clients] start calling the company. They want me back. They want me back.

Megan: They miss you when you’re down there.

Renata: They miss me and they keep calling [the agency], calling, and [the agency’s coordinator] have to pull me back here.

Here, Renata, a HHA, reports the pride she experiences when she feels needed by her agency and clients, but that she feels “pulled” away from her family in the Dominican Republic.

Additionally, ample vacation time is hard to come by in caregiving jobs that offer low pay and few benefits, even at full-time status. While Tina loves to “help the people,” she complains about the pay, specifically the lack of raises and time off:

Megan: What do you dislike the most your job?
Tina: Pay. I think it’s too cheap! (Tina laughs) Because we are paying for the car, the gasoline, my energy. It’s too cheap; not fair. Very cheap here. They never increase the pay ever. I got the same pay for about five years. It’s terrible (Tina laughs). But [the agency coordinator] is nice, but the pay – no benefits, nothing. No sick day. If you are not working on the holidays, they don’t pay you. No bonus. No gift on the holidays. Christmas: they don’t give you nothing.

Megan: Do you see yourself continuing to work in home health/home care?
Tina: I think so. I like it. I can work in this job for all my life, but I want better pay and benefits.

In Tina’s view, the amount of energy she expends in caring for her clients, in addition to the often overlooked frustrations of traveling to clients all around the city, exceeds the remuneration she receives from her agency. Tina feels as though she has to work multiple jobs to make ends meet and tend to her own family. If she received better pay and benefits, she would be much more content in her line of work.

With the scarcity of paid time off in home care, especially, when a caregiver is reliant on only one or two clients for shifts, leaving for an extended period of time can place the worker in a precarious position. Felix, a home care worker from St. Kitts, illustrates this point:

Felix: Yes. They needed help. About five years ago, I was ready to resign and go and take care of [my father] but he passed away at the same time I put in. Well actually I had my resignation in my hand because I went down to see him in St. Thomas and I saw he was sick very bad and he said he wants me to be there. Then I come back up and I had my papers in my hand to go back and they call me and tell me he passed. That’s why I’m still here because I would have been back in St. Thomas. If he would be living, I would have been there still and if I had some more time, then I would have stayed there. I wouldn’t have been back here. Lucky that he passed when I was here so I could stay here.

Felix’s tight schedule and the absence of family members to care for his father in St. Thomas compelled him to move to provide care for his father around the
clock. But because of his short allotted vacation time, Felix had to return to the U.S. with a drafted resignation letter to bring to his agency. During this time, Felix’s father passed away. In the end, Felix considers the timing of his father’s death to be favorable because he was able to keep his job in Boston. Felix recognizes, however, that he would have stayed longer if he had some more time.

While many of the senior citizens value the emotional and physical work their caregivers provide, clients’ families occasionally ignore, discount, or criticize the important work that paid caregivers perform to maintain an elder’s quality of life. When a caregiver feels a sense of kinship with the client, it can be especially hurtful for him or her to be subject to such behavior from the client’s family members. To be sure, many family members of clients are appreciative of the roles caregivers play in their aging relatives’ lives. But, when the “family ideology” framework is considered, it often resembles two separate spheres: the client-and-caregiver and the client-and-client’s family, with little overlap. When asked if he sees and interacts with residents’ families, Ricardo explains:

Ricardo: Some. Some families, yeah. Everyone is different. In Haiti, we keep the people home. Here they can’t keep people home because it’s a busy country. Busy country. That’s why they need some place to take care. Some families know what you do, and they appreciate it. Some families don’t care. Even if they saw you in a bad situation, some accident happen with their father, you
have to take care, you have to put your hand (Ricardo gestures) and you have to clean him. They come in, and they don’t even say hi to you.

Megan: Really?
Ricardo: Yeah. They don’t even say hi to you. I don’t mind. I just do my job, I take care of them and I don’t mind. There’s some family, some are nice. They come in, they’re nice to you, talking to you. They’re very nice, talking to you about, “How does my mother feel? How does my father feel?” But, some would not even say hi to me. I don’t mind about that. Sometimes it hurts you, because if you come in, and I saw your mother and think of my mother, I just come in, “Hi mom!” I’m thinking of my mother, and you never say hi to me? Even if you know it’s my job. That’s my job to do it, but show me you feel I do something, because I take care of you. They don’t do that. Some, they don’t do that. Some are so rude...

Megan: Rude?
Ricardo: Yeah, when they come in – anything – they’re going to report it. Any little thing, they go to the office, something like that. That’s the way it is.

Although he offsets his hurt by saying he “doesn’t mind” that his client’s family ignores his hard work, it is clear that Ricardo feels offended when he’s treating the client like his own family member and the families do little to acknowledge his existence. He sees himself as playing a vital role in his client’s emotional and physical wellbeing by filling the void left behind due to his client’s family’s schedules, and such lack of recognition, or worse, unfounded critique, is upsetting to Ricardo’s sense of self.

Stanley and Michelle, both CNAs from Haiti, echo Ricardo’s frustrations. When asked about caregiver-client’s family relationships, Stanley responds that they are, “Okay, some of them. They have different personalities, some of them
are nice, some of them are too needy, you know? Some of them are never happy about the care that you did, only the mistake. You don’t do enough, you know?"

Stanley, like Ricardo, finds that families are more likely to criticize or report issues rather than express gratitude or positive reinforcement for the care he provides. Michelle, who like Ricardo, feels overlooked by her client’s families, decides the best method is to ignore their behavior and focus on her true purpose, caring for the client. She notes, “Some residents like to...When they see you, they are happy to see you because they know you’re going to give good care. Even those, I’m talking to, there was this family coming. They don’t say hi to me. I don’t mind because I’m working with my resident, you understand what I’m saying?”

To be sure, most clients had little contact with clients’ families due to the time and distance pressures that created the need for paid caregiving in the first place. When they did discuss relationships with (present) families, however, some of the caregivers recalled positive interactions with family members, mostly from those who showed their appreciation and gratitude for the work the caregivers perform for the aging relative. For example, Jenniflore, a CNA from Haiti who works in a nursing home, recalls mixed experiences with families; some very positive:
Megan: Do you see many of the patients’ families around?
Jenniflore: Of course, yes.
Megan: How is your relationship with them?
Jenniflore: For me, I don’t have any problem with them. We are always hugging. When they come, they kiss me, hug me. “Thank you, Jenniflore for the job you’ve done for my mother, for my father. You’ve been nice to them.” Like I told you, some people, some people...But most of the people I’ve been taking care of, I don’t have any problem with them.

Efie, a Ghanaian CNA, also had positive interactions with several of her clients’ family members, yet she struggled with the limits of the CNA, whereby she could not offer maximum information due to her credential level and health privacy laws:

Megan: Do you have any interaction with the families of the residents?
Efie: Mm-hmm. Let’s say Mrs. Smith will say, “Oh, I like this little girl. She’s so nice to me, blah, blah, blah.” They will come and say, "Well, thank you so much. My mom said a whole lot of stuff about you. We appreciate those kinds of stuff.” And then sometimes they will come to you and say, “Oh, how is my mom doing?” But, as a CNA I can’t give every detail to them because I don’t know who they are. I don’t know who... The best thing that I could, I would just, "Oh, your mom is fine today" but if the questions are too deep, I would say, "Can you go to my charge nurse or go to the boss? Because I don’t know anything about your mom.” That’s all.

More often than not, respondents mention the “too demanding” nature of many family members and unrealistic expectations they placed on CNAs and HHAs given the bureaucratic structures of nursing homes and the limited job definitions of home care. To Sharon, a RN from Kenya with a CNA background, unrealistic demands from largely uninvolved families are particularly ironic and
Sharon: It is [stressful]. Yeah, it is because sometimes the family members will come in. Now I’m starting to get it or rather in a few years I’ve gotten it. I would walk in and most of the time it’s probably, “The hearing aids are not working!” They’d be yelling at you. You’re thinking, “I’ll be lucky if I know where the hearing aids are, forget the batteries that’s the least of my worries because you know what? I can talk to that patient and they will hear me fine.” They go, “Oh no, they’re not working. How long has she had this?” You’d be thinking, “If you paid attention probably you would have noticed that they’ve been broken for a while.” They’d be yelling at you and they’re probably venting. Some of them, it’s not denial. They’re probably hoping, they can’t take care of their parents but then they want to make sure that they’re involved in the care but yet they’re yelling at the nurses. You’re like, “All right.” You have to take care and of course you have to maintain a face and be like, “Yeah we’ll follow it up and all that,” because you can’t start telling them what you think. We would probably lose our jobs if we said it.

In her angst, Sharon posits that if the family members truly cared, they would have noticed the problems much earlier. As a caregiver who feels fictive kinship for her patients, frustrated families that rarely come around are particularly grating. Sharon recognizes that the structure of nursing homes inhibits full-time ideal care for each individual, but she resents family members taking out their irritation on her. She continues,

Megan: What do you dislike the most about your job?
Sharon: Definitely demanding families. Overly, it’s okay to ask for something that I can give you and something that’s attainable but it’s not okay to be asking... we had a resident, they were asking for their mother to be showered every day. It’s like, “Yeah we would love to do that but hold on.” The CNAs all have assigned patients to dress, get them washed, change them if they’re wet, feed them and all that. They would love to give everybody a shower but it’s not
possible. What they do, they will attend to every other person and they have five
a day. If you get a shower morning this week and then you get another one in
the evening same week, you get two showers in a week. They’re asking for
somebody to be showered every day in the morning; that’s not even logical. If
they were home I would understand, yeah you would help them shower every
day which is fine. It’s not possible. It’s not realistic, unrealistic families.

James, another RN from Kenya, takes issue with clients’ family members who
put their own wishes before that of the client and who argue with him over the
best course of care:

Megan: What do you feel is the most difficult part of your job?
James: It’s mostly dealing with families who disagree with what we think would
be the best, especially for an elderly who doesn’t know what’s going on but they
are suffering. But the family members want to fight back and have things done
their way and not … as in they forget the whole picture that they are taking care
of this patient, but it’s about you, not your parent or your spouse. Because we
have people who fight like that. They are arguing and fighting and they forget
we’re here to take care of the client.

For each of the caregivers, the caregiver-client relationship is the most important
to cultivate. Yet, given the feelings of responsibility that are infused with fictive
kinship and the efforts caregivers take to provide quality care, criticism or
gratitude displayed by the client’s biological family members carries a lot of
weight and has deep emotional consequences.

   Fictive kinship bonds can be very meaningful for both the clients and
caregivers. According to caregivers, affection, kindness, respect, and patience
are essential to emotional wellbeing and physical longevity. In turn, caregivers
feel proud of the bonds they develop with their clients, and view sacrifices on their own time and distance from their biological families as necessary and worthwhile. When clients take on a fictive kinship role for caregivers, losing a client to the hospital (in the case of home care) or worse, to death, can be very painful for the caregivers. Allison, a home health aide from Jamaica, explains, “Because they’re like … after a while, they become like your family. So that hurts, seeing them going through all that. Like when they come in they are fine, the next minute – they die.” Dealing with the death of a client can be especially hard when the client does not have any biological family members. James provides an illuminating example:

James: We have some tough days; we have our own favorite residents that die and everybody … I remember one time we had this resident who did not have any family members. Power - What do you call them? Her healthcare proxy or healthcare agent was a lawyer! We didn’t know she did not have any family members; the day she died there was not a dry eye in that building because she used to walk around trying to literally give us her coats! Her inner clothes, she’d be like, “If this can fit you…” You know, in a nice way, she’s trying to just be helpful. Every time we see her we’d be like, “Oh, oh here she comes she’s going to bring me something.” The day she dies we were like, she was like a family member, she used to come and bug us because she knows there’s nobody else to bug. I think towards the end we got to see that because she was so dependent on us and you could see that she sees you, but mentally, she’s gone. But she sees you and she holds your hands and she’s like, “Oh thank you for coming,” I’m like, “Okay, I’ve been here all day but…” I mean, for her to remember you that much she’s going to say thank you, that’s very rewarding.
The caregivers in this study prove that emotion work is a complex skill whereby they must learn to read the client, cope with difficult attitudes and behaviors, build trust and intimacy, and occasionally learn to let go of a person who has become “like family” when that person gets admitted to a hospital or, in many cases, passes away.

*Emotional Labor: Ensuring Dignity for the Adult Dependent*

Though the trope of the “ideal” American family as a heterosexual nuclear unit has broadened with social acceptance to accommodate alternative forms such as multi-generational households, same-sex marriage, and single parenthood, the assumption that family members provide essential reproductive labor remains intact. Thus, despite the composition, a family is imagined as a unit dependent on one another for basic needs, both physical e.g. providing food and shelter and emotional support. The specific practices of reproductive labor vary as care recipients pass throughout the life course, however, where evolving needs call for different types of nurturing (Baldassar 2007). Each stage brings its own challenges and rewards to the caregiver: a parent may tire of running around after an excitable child but find joy in snuggling during a bedtime story, and an adult daughter or son may discover that the same clarity of needs that comes from an articulate aging parent can be both useful in determining care but
also negative when such wishes are accompanied by insults or an excessive
demand on time.

The increased commodification of caregiving has placed the tasks of
reproductive labor in the hands of paid caregivers such as the immigrants
interviewed in this study, several of whom have experience working with both
children and geriatrics. Myra thoughtfully reflects on the varied challenges
brought about in caring for different cohorts:

Myra: Geriatrics is a little tough just because the older people, they are bigger
and they speak to you. They say things that you might not want to hear but they
do say it to you, like cursing and telling you to go back where you came from.
Asking, “How did you get into this country? Did you swim? Did you swim into
the United States?” But it is fun working with some of them because they tell you
stories like how they ended up being here, which is really interesting to know
about other people.

Despite difficult encounters with racially or culturally insensitive clients, Myra
chooses to emphasize the rewarding exchanges she initiates and the emotional
bonds she builds with her clients when she asks them about their pasts, a form of
reproductive labor unique to caring for aging populations. In the face of
maltreatment from a client, caregivers also try to compartmentalize the client’s
behavior as a result of age-related illness. They think about the life trajectory of
the client and sympathize with how difficult it must be to lose one’s capacities.
Caregivers attempt to view and understand their clients as human beings with
interesting histories filled with joys and sorrows that have produced the person they care for today.

As discussed in the previous section, embracing the role of an absent family member is a task that these caregivers take very seriously. They view the job as an important one where they are ultimately responsible to ensure the client is comfortable, happy, and safe. To understand what the client needs to accomplish these goals often involves caregivers projecting their own feelings of how they would want to be treated should they need a caregiver in the future.

Esther explains that her past experience caring for her mother shapes the way she cares for her clients and she also projects her own desires for future care through her caregiving behavior. She notes, “You know, I feel like it's me. I'm already getting old. I always say, ‘God, I hope you give me somebody like that to help me. To be comfortable with them, to trust them. Who will put something right there where you need it to find it again.’” Providing “good care” to their clients, even at the risk of taking on extra work beyond the job description, becomes just as essential as ensuring quality care for family members. In this sense, these caregivers practice “compassionate care, [which] according to Roach (2007), requires immersion into the pain, brokenness, fear, and anguish of another, even when that person is a stranger” (Burnell and Agan 2013). By
“putting themselves in the client’s shoes,” these caregivers practice empathy and compassion towards clients.

In other words, just as these caregivers envisioned their aging relatives while they cared for their clients, they also reflected on their own mortality and wishes for future care when making judgments on how best to care. One of the biggest fears for many of the caregivers in this study was losing one’s independence and the dignity associated with being able to care for oneself at full physical and mental capacity. Witnessing the physical and mental declines of the aging process encouraged caregivers to highlight the compassion they felt towards the clients’ struggles and the strategies they practice to make sure the clients feel respected. Kwesi articulates:

A good caregiver we’ll say is somebody who has the interest of the person that he’s taking care of, and also who puts his or her shoes in that person’s shoe and gives care because life is a circle. When you are younger, you can dress yourself. You can choose to go to whatever party you want to go. When you get older, at some point, you need to be dressed. You’ll stretch up your hands to be dressed, and you will even be taken to places that you don’t want to go. So that is life. If you, the caregiver, have compassion and passion; it goes a long way. You tend to treat the person the way you would like to be treated, if you were in his or her position. It’s very important that the providers are compassionate.

The average age of the caregivers interviewed was forty-eight – representative of the national sample of direct care workers (PHInational.org 2011). Some of the participants were in their sixties and seventies, and witnessing the mental and physical declines of the aging process made care planning hit extremely close to home.
For the caregivers in this study, then, emotion work centered on bestowing dignity for their fictive kin, the dependent client: making sure the client felt like a whole person, capable of tending to themselves but not feeling embarrassed to receive help when needed. This was achieved through myriad ways: discreetly cleaning a client after an unanticipated bowel movement, dressing them in clothes that make them feel happy and polished, laughing with them and displaying genuine interest in hearing stories about their pasts. Given that a majority of their clients had severe needs, especially those residing in skilled nursing facilities, caregivers attempted to provide a delicate balance between nurturing and encouraging independence.

“Once a man, twice a child.” - Felix (St. Kitts), HHA/CNA

To be sure, several caregivers in this study underscored the dependence of their clients and the pride they felt in “feeling needed and helpful” in being the sole provider of physical and emotional care for the most vulnerable. As discussed earlier, caregivers would refer to their clients as “baby” despite the client nearing centenarian status. Female caregivers, especially, occasionally infantilized their clients, remarking how adults become babies once again as their physical and mental capacities decline. Beatrice, a home health aide from Haiti, points out:
Because sometimes they tell me, “You make me happy. You make me alive. I now love a shower. [Before], I don’t like shower! I don’t like shower! Til you, you make me love shower.” Sometimes I’m singing, I’m singing for her: “Come to shower! Come to take a short shower!” And sometimes I’m singing, “I love you, you love me!” And that is my baby. Some of them are like babies.

Not only does Beatrice delight in her expertise at changing the perspective and behavior of her client, she also takes to singing popular children’s songs to soothe and entertain her adult client. While somewhat extreme, Beatrice is not alone in suggesting geriatrics are “big babies”:

Fabiola: Everybody is not bad. When you came you were a baby and when you go you’re a baby. You have to be patient with that baby. Yes, you have to be patient. They’re babies now. Ninety-two is baby, everybody is baby. You expect them not to do anything for you. When I was working before in the nursing home they spit on me. I don’t see nothing; just a big baby. You have to like that job. If you don’t like it and you only do it for the money, you can’t do it. A lot of people can’t do it, no. You can’t do it.

Fabiola recognizes that elderly patients require the same level of patience as infant care. Once again, the caregiver views decreased capacity as a defense mechanism against hurtful behavior. This strategy is one of many coping tactics that will be discussed in greater detail in the following chapter.

While both male and female caregivers recognized the dependency of the elderly, males were more likely to note their caregiving role as “assisting” the clients rather than “babying” the clients.

Felix (St. Kitts): All my clients, I love them. They love me. It’s like they have to
get to know me and I have to get to know them. Some of them…the aged population says, “Why you coming to my house? I don't need help.” I said, “Well one of these days, I will need help.” So as the saying goes: once a man, twice a child. I said, “Your son or your daughter or your nephew might help me one of these days you never know, so I’m just here to help you along with what you cannot do for yourself but I will let you do as much as you can do. That’s no problem. But if you cannot do certain things, I’m here to help you. We can do it together and make the day go by faster and then I will get out of your way.” I usually try to give everybody independence and then if they can’t, then I would help them.

Felix tries to find a comfortable balance between assisting the client and encouraging independence. He recognizes that it is difficult to lose aspects of control over one’s life and body, and tries to reassure his clients that what they are going through is a natural fact of life and that his method of caregiving will be unobtrusive. In fact, Felix claims that the most important task of his job is “to see somebody get up in the morning and help themselves while I'm helping them and later on in the process, they accomplish what they want to accomplish. That’s my, how to put it, my goal really.” Felix takes pride in seeing his clients improve with his assistance. He views clients as having some agency instead of seeing them as completely helpless.

“That people they believe in work and in moving, doing things, doing that. That’s how they were [in Jamaica].” – Grace, HHA/CNA in an Assisted Living Facility

Several of the immigrant caregivers compared the striking dependency of
the elders they cared for in the United States to what they perceived as “active” aging relatives in the countries of origin. Viewing this contrast through a transnational lens, participants determined that while the elderly deserved benefits and assistance in the U.S., the accessibility of care, early retirement, and prevalence of easy-to-prepare processed food occasionally worked to the detriment of America’s elderly population. In recalling stories about their pasts, participants spoke fondly of the activity of elders who “worked right up until the day they died,” and that such independence and action kept them young.

Mona, a Haitian nurse at a skilled nursing facility, introduces such a comparison:

The population is still really different. The age group also is different. Like I can tell you, I can have a hundred year old grandmother and grandfather that are still at home doing everything; a 75-year-old grandmother that’s still doing everything. They go outside. They go to church or they’ll hear you sing. Maybe sometimes you even have patient here who is 60 years old or 74 years old and they’re getting sick. They cannot help themselves. Somebody has to always be there to take care of them, to take care of them. Because back in Haiti, like grandmothers at that age, they’re still home doing the laundry, doing that flushing hose and even doing the laundry with like no washing machine. They clean clothes by hand and all that.

Similarly, Grace values the active lifestyle of her aging relatives and argues that it “keeps them young”:

Grace (Jamaica): My grandparents, they were all people who worked right until death, you know, they go around, do things, visit. My grandmother, she was going to church right until the time she got sick. My grandfather, he was a farmer, and he was always riding his donkey. It wasn’t like they got sick and
had to stay in the home for somebody to care for them, and things like that, it was not that. I remember when my grandmother got sick. I was really small, and she went to the hospital in Kingston, and that’s where she passed away, so it’s not like here where they went into nursing home or anything. They were pretty independent right until the end. Those people, they believe in work and in moving, doing things, doing that. That’s how they were.

Grace considers an active self-sufficient lifestyle as contributing to a healthy retirement.

These stories presented an interesting mix of celebrating the communalism of their former homelands, whereby senior citizens always had a friend or family member nearby for emotional comfort and help with ADLs, yet the elders themselves were largely self-sufficient on a day to day basis. Myra explains that although the U.S. has “everything that is needed in the health field and that there is money to be paid to pay people to take care of other people,” she ultimately considers the model of extended family care in Cameroon as a strength. She explains:

Yeah, because the elderly are not all that reliable [reliant] like the ones here. They like walking. There are not many cars. Not everyone has a car in Cameroon that you can get in a car and go somewhere. No, we walk long distance and the elderly they walk too, they go to the farms. They stay strong until some of them just die while they are still strong. They don’t... there is not much lying down in bed before you die. It is not that much. It is not common.

Similarly, when I asked Fabiola what she expected future needs to be for her aging family in Haiti she replies:
I don’t know. Let’s say what we do with the kids. They go out and they have fun. Older people in Haiti they go outside, they play dominoes, they have family, they talk, they garden. Older people do that. They do everything because they don’t like to stay or sit down. They are active.

These caregivers contrasted these examples with U.S.-based elders who they saw as lonely and isolated from family, but who were much more dependent on the help of caregivers. These immigrant caregivers attempted to provide a space where they were not only present to fill the emotional void, then, but also to encourage some independence that they felt was vital to aging at a slower rate. This transnational perspective, coupled with self-projection of losing one’s capacities, informed caregivers on the necessity of providing respect and dignity for seniors.

CONTEXT MATTERS: MANIFESTATIONS OF RESPECT AND DIGNITY IN HOME AND INSTITUTIONAL SETTINGS

Regardless of how “hands-on” the caregivers felt they needed to be, all of the participants emphasized that the clients deserved to be treated with respect. This involved taking the clients’ feelings into account and occasionally incorporating their perspectives into their care plan. Samuel, a home health aide with CNA training recognizes the importance of conveying respect while caring:
Samuel (Haiti): Anyway when someone is in need, they are dependent, they are suffering. With their limitations, you give them their dignity while you are taking care of them. You communicate respectfully with them and they feel life is coming along. That’s why you will say, “Okay, all right, is it okay to turn off the light because ... Is it okay to turn on because I can barely see what I’m doing?” You need to take care of the person, obviously. You can’t just light up even if it’s something logical. However by asking, “Is it okay to turn that?” “Oh, go ahead!” Now you put them in a position that they feel okay, they feel respected, they feel they own something and while they’re limited, somebody can still respect them while they are like that.

To be sure, a higher level of client input was easier to accomplish in home care settings where the caregiver held more autonomy over the order of tasks, but nursing home CNAs and assisted living HHAs also got creative with how they conveyed to clients that their opinions mattered. Wideline, a HHA/CNA, argues that a central component of quality care is making the clients feel as though they are heard and that their opinions are valued. She states, “Well, my approach is different. When I go there, I don’t go there to tell...No, I have to know your feelings first, and I let you tell me what do you want me to do for you and how you want things to be done. Then I will add my input.” While Wideline commits to a schedule, she wants the client to feel comfortable with the course of care.

Thus, while both home care and nursing home workers valued the same results, the emotion work of providing dignity occasionally manifested in
different ways influenced by the advantages and obstacles set forth by the context. The context of care impacted not only the amount of time caregivers had with each client, but also the level of dependency of the clients, whereby clients in skilled nursing facilities were more often afflicted with dementia and Alzheimer’s diseases that greatly impacted communication and the ability to build emotional bonds. Farah, a Haitian caregiver who has worked in both home care and institutional settings, explains:

Megan: Are you able to establish a relationship with your patients at the nursing home in the same way?
Farah: You know, I do eleven [PM] to seven [AM]. Sometimes, she’s sleeping and sometimes they are confused, and it’s not the same thing for the home care. For the home care, she’s alert, she talks to you, she does everything, she washes, and she does some laundry. She needs help, but she’s not all dependent. But in the nursing home, almost all of them are dependent and maybe confused.

Each setting presented opportunities for redefining emotional connections: in home care, caregivers described establishing bonds over relational work while institutional caregivers highlighted the emotional benefits that come from cleaning, dressing, or checking up on the client in ways that they felt conveyed love and provided dignity.

*Emotion Work in Home Care: Building Relational Bonds with Boundaries*

With carework so infused with notions of love and family, relational bonds took on a central role in the client-caregiver relationship. As mentioned
earlier, caregivers attempt to fill an emotional void for their clients. Given that maintaining dignity and conveying respect were so central to the notion of appropriate caregiving for an elder individual, caregivers attempted to play the role of a compassionate and interested family member or friend. The home care setting, which allowed caregivers to have more time with fewer clients, enabled caregivers to spend more of their schedule “relating” to clients, and performing work on the client’s terms. Felix explains:

Felix: Maybe they had heavy chore cleaning so I clean the stove, clean the floor, clean the bathrooms, and wash dishes, whatever they need me to do. Then if there is perhaps time left over we sit down. We talk about baseball, basketball. We talk about different things. Because most of these people, they are old but they still are enjoying the sports and what else they usually enjoy. Some of them, I read with them and sometimes we play cards with them; play games. Then I say, “I have to leave now. My time is up.” Then when I finish that, if I have a next one, I go and do the same thing over if they have heavy chore, home health aide, and then I finish. Like I say, it just depends on how many clients I have that day.

While Felix feels that heavy chores are important tasks of caregiving, he highlights the value of engaging with his clients on an emotional level. Felix recognizes that his clients enjoy playing games and talking about things they care about, and tries to finish his other tasks early to devote more of his time to this essential task. Samuel also views emotional engagement as a very real health benefit for his clients. He explains:
Samuel: It’s very important and has a psychological impact on the person. You take care of their emotional needs, you give them their dignity, you respect them, you communicate with them and you make sure that their need is taken care of as well, the best. You communicate with them as a friend and sometime my job is over and then I can stay over thirty minutes, over an hour more just chatting with them, watching TV. “Oh is that what he said to Judge Judy? Oh that sounds...” things like that. Every time you knock at the door they say, “Oh, my friend is there!” They open it for you. They are so excited about it. Yeah, every time I see a man, “I’ll see you next time. Tuesday again, right?” I say, “Yeah, I’ll be there.” “You’re sure?” “Yes.” It is a very great experience. Even the way you take care, you’re not rushing, you’re not hurrying because you take reasonable time, you give them pace and you make sure that you take care of their safety which is the number one.

As Samuel’s story illustrates, the boundaries between client/friend and home/work in the home care setting occasionally get blurred and caregivers feel obligated to spend extra time with clients. Gaelle, a HHA and CNA who works both in an assisted living facility and at private homes, offers another example:

Gaelle: Because everybody has a story they tell. Because sometimes if I have to take five or ten minutes after I finish with my job or my work I sit with them and like you’re interviewing me you know, I ask, “How was your family, how are you now, are you married, were you married, do you have children?” You know? And they’re happy when you talk about it. Cause sometimes – I have two of them that kept saying, “How come I don’t see you anymore?” I said, “Sometimes I’m not in the building. I work outside too in the community,” I said. “I thought you have something against me!” I said, “No, no, no. It’s because I don’t have time to see you but I will.” You know? “I miss you.” You know we used to sit and talk and...

Although she devotes time “off the clock” to emotional labor, Gaelle feels guilty when her clients demand more from her. In her book, The Caring Self: The Work
Experiences of Home Care Aides, Clare Stacey (2011) finds that home care workers often find themselves “going beyond the job description” by spending extra time and doing extra tasks when the line between home and work is more ambiguous. Stephanie, a home health aide from Haiti sees this happen often and struggles to manage the expectations of her clients:

Stephanie (Haiti): The important thing is you need to do your job very good, to get the good relationship with your clients... If they tell you what you are to do, if it’s not your job, you can explain, “It’s not my job. I can’t do it.” If they tell you, “I need to go to the market.” Say, “I can’t drive you over there because if I go, it’s not good for me, for you, if something happened.” You need to let them know what’s going to happen in the future for your job, too. Yeah. Megan: Do you find that they ask you to do extra things a lot? Stephanie: Yeah.

Indeed, such personal relationships with fictive kin can make it difficult for caregivers to “tear themselves away” from a lonely client, in ways the rigidity of nursing home work avoids.

Not all relational work is easy, as Renata’s story below indicates. But despite dealing with a “nasty client” who treats her “like a maid,” Renata, a HHA from the Dominican Republic still prefers to work in the home care setting because she feels she can more accurately relate to her clients on a personal level:

Megan: How would you compare training there versus working in a home care setting? Renata: It’s because in the nursing home they give you like, for example, eight people or seven, and you have to be doing everything by time. In eight hours,
it’s like you have this package. You know that you have to put that package in one place and that’s it. You don’t even have time to talk to them about their feelings. [But] in the home, sometimes there are nasty people when you have to take care of some people in the home health, something like that …

Megan: In home health?
Renata: Home health, because they think that you are nothing. Yeah, sometimes when you go to take care of some people in their house, they think that you are nothing. That you don’t study, that you don’t have any knowledge or something like that. And they are very nasty; they can get very nasty with you. But I prefer even still the home, because in the home you can be close to them, talk to them and the nursing home, it’s an object. You know, something, like you just put it there…

Megan: So overall you prefer to work in the home because you can be closer to them?
Renata: Uh huh.
Megan: So when you said that they can be nasty, how, what do they do?
Renata: Not recently something has happened like that, but anyway I continue with him. Okay, I finish doing the thing and he doesn’t like that. I never say anything to anybody, but I don’t like that, because he thinks that I’m his maid. But, you know, he’s old and he’s going to die pretty soon. He has some problem in the heart. I’m going to live, going with the flow. Yeah, I go with the flow.

To Renata, personal connections are difficult to establish in a nursing home setting. She feels like a better caregiver when she can treat her client like a subject – a human being with feelings and needs, as opposed to the object-like treatment she perceives nursing homes to offer.

*Meaning Making in Nursing Homes: Infusing ADLs with Emotion*

As Renata articulated, she preferred the ability to practice relational emotional labor even with one difficult patient versus not having enough time to tend to “too many” patients in a nursing home – physically or emotionally.
Indeed, one of the biggest complaints about nursing homes was the chronic problem of understaffing, whereby the caregivers felt they were assigned too many clients to adequately perform the required tasks, a byproduct of the funding structures outlined in Chapter Three. Not only did they feel unable to “just sit and talk” with the residents, they felt rushed in bathing, dressing, and feeding the clients to the high standards they set for themselves as workers.

Ricardo paints a portrait of the problems “short-staffing” can create:

Ricardo: Hard is when you’re short staffed. When you’re not short, you know the CNA part, you know what to do, it’s not hard. When you’re short, you have ten, eleven, twelve patients; total care. It’s very hard for you to work … you have to know what to do, to help twelve patients. Total care. To get them cleaned, to get the food, to get dressed, to get everything. It’s very hard. That’s the hard part of the CNA. After that, if you know what to do, it’s not hard. When you’re short staffed though, it’s very hard.

Sharon, a nurse from Kenya, also feels the same time crunch and bemoans the emphasis on chartable tasks at the expense of emotional care:

Sharon: It’s too rushed. There’s always – it’s so rushed. On my side, if I work on a 3–11 shift, I have seventeen patients. Out of those seventeen patients, I have eight hours. During those eight hours I’m supposed to take out my lunch break which actually never happens. If I take out my lunch break, that leaves seven and a half hours. Out of that seven and a half hours, I have to go on the chart and make sure that they’re getting the right thing and make sure that the order was put in right. If it wasn’t put in right then I’m on the phone calling the doctor who I can’t reach so that I can fix it. That eats up another probably one hour give or take so now I have six hours left. I go to the first patient. They probably will refuse their pills. We’ll try with apple sauce; let me go get apple sauce and all that. Then in the process somebody is trying to climb out so the alarm is going...
off. By the time I get to giving them their meds that’s when I’m supposed to be asking them, “How is your day?” It’s like, “Here you go, see you later.” I don’t even remember apart from that resident who tells me about her cats and all that. The other one I don’t even remember the last time I asked them, “How was your day?” I feel guilty because I should have the time to ask them, “How was your day?” It’s not just about “Here is your Tylenol,” period. We are always short staffed.

Megan: What do you describe as the most important task of your job?
Sharon: It’s most important that meds are passed because it will look pretty on paper and you won’t get any citations. The most important thing is to make sure everyone is taken care of emotionally; physically, yes, but emotionally, emotional pain and all that would bring you down faster than physical neglect or whatever. But, you get, if you have like we call them holes, holes is if somebody didn’t sign [off on a chart] because then it says “oh if it wasn’t documented it wasn’t done.” It’s like you forgot that I was sitting with them talking to them or taking care of them emotionally but no.

The fear of maltreatment coupled with strict state guidelines associated with Medicaid funding has created a system whereby nursing home and similar facilities’ administrations focus on bureaucratic and administrative standards when measuring quality care. One of the biggest complaints of the participants is the act of checking the box and finishing paperwork without enough time allotted for proper care to form strong relational bonds. It is important to note that Sharon had experience as a CNA prior to her position as RN, and she often sympathizes with the trials nursing assistants experience in their dealings with clients and staff. However, the focus she imparts on emotion work and the problem of short-staffing at the RN level indicates that these problems are
prevalent throughout the nursing hierarchy and point to a fundamental problem with the administration and structure of institutional care as a whole.

Providing Entertainment: Singing, Dancing and Comedy

Despite the time crunch that nursing home workers feel inhibits the traditional relational practices of engaging in conversation, these caregivers find unique ways to tend to the emotional needs of their clients. Caregivers discuss how they sing, dance, or tell the occasional joke in passing to elicit happiness and comfort their clients. When chatting about her relationship with clients, Cassandra, a HHA/CNA at an assisted living facility remarks, “Always, they always call me, ‘Come here! Come here!’ And then I always dance in front of them. Yeah. And let me see. I like to make them happy. Yeah.” Gaelle also notes how in addition to helping her clients “to cut the food,” she also “you know, sometimes I dance for them, I’ll sing and make them happy, you know.” James, a RN from Kenya, explains how he puts “comedy into everything” he does:

Megan: Comedy?
James: Yes, I listen to a lot of Comedy Central, I go on YouTube. I try and bring that comedy to the work that I do. So I usually tell the patients, I’m here to treat and entertain. They have to trust you; there’s a way they’re going to remember you. [I’ll say] you’re in good hands like All State. They get a kick out of those little tiny things and they see them on TV and they will remember you. I mean…if somebody can remember you and you go to see them tomorrow and
you know they are not all with it, if they can just connect your name and that, that’s something. That means you did something right.

Thus, although the exchanges may be brief, caregivers make sure to devote whatever extra time they have beyond ADLs to keeping their clients emotionally satisfied. To James, Cassandra, and Gaelle, little things like singing, dancing, and using a catch phrase, build trust and enhance bonds with the clients.

*Keeping the Client Clean: “You see that smile on their face and you look at them; they’re nice and neat, you see that’s it; it’s just that smile.” – Mercy (Nigeria)*

One of the most complained about tasks of direct care was dealing with patients’ bowel movements. As Darline astutely points out:

Megan: What do you feel is the most difficult part, the hardest part of your job? Darline: You want me to tell you? You really do? Megan: I do. Darline: Okay. I’m telling you, sometimes I can’t...I don’t want to even deal with my own poop, and you don’t want to have to deal with somebody else’s poop. It’s hard. That’s the hardest. That’s the only reason that I hate it. If it was like give the person a shower, feed them, and do stuff like this, I might not you know, love it, but I will like it. But this one is like, mm-mmm. I won’t be able to deal with my own and then you have to deal with somebody else’s sometimes. It’s like for the whole eight hours, I’m telling you, from 7 o’clock to 3 o’clock, you have to deal with that.

To be sure, the caregivers view “putting up with doo-doo” as one of the least appealing aspects of the job, but they cast such sensory offenses to the side and do the dirty work because they know it needs to be done. While it may be
frustrating to clean up the clients after a “BM” only for the client to have another accident moments later, caregivers often sympathize with clients who have lost control of their bodily functions. They view the task of tending quickly and discreetly to such accidents as essential and necessary to preserve the client’s dignity. Mirlande explains how, above all, keeping the client clean is the most important part of her job at the assisted living facility:

Mirlande (Haiti): The most important thing that I do, let me say this. If you have a child, and you left the child dirty, hungry; you wake up in the morning, you don’t care about that child, don’t expect the child to have a good day. The same, even with the elderly, if you come, you must do the right thing, like give them what they need: shower, smell good, feel good. That’s what they need because when you get into their apartment, it smells because they pee on themselves, they go on themselves. So that’s the most important thing: keep them clean. Keep them clean. And the difference from when you go and when you leave, there’s a big difference. And they tell you, “Oh, I feel good, thank you.” So that means you did something they liked. So to me, it is keeping them clean. That is the most important thing you can do to them.

James echoes the importance of cleaning the client:

James (Kenya): It’s so rewarding, it is so rewarding. You walk in to somebody who is so super soiled, they look so disheveled and all that and by the time you get them out of that room, they are nice, neat, they smell good, they are smiling, they are happy, and you get a thank you most of the times. That just makes your day; you feel you made this person’s life much better that day. You prevented them from being stressed and shortening their life, you made them up.

Mirlande and James see the embarrassment on the face of their client who has had a bathroom-related accident transform into a smile and gratitude after they
tend to the incident. They feel that leaving the client “disheveled” and in his/her own filth causes stress for the client, ultimately producing “a bad day” or worse, a shortened life. They equate neatness and cleanliness with dignity, and attempt to elicit such smiles and positive emotion from the clients. When he or she accomplishes such a task, the caregiver feels s/he has succeeded in comforting the client. When I asked Farah, “What do you like most about your job?” Farah responded, “I am very satisfied. I feel comfortable and enjoy when I come, I find a patient very dirty, and I put my two gloves, and I take care, and after the patient was very nice, clean. I feel …ohhhh I can’t describe you what I feel. Because somebody cares about BM…poo.” Bathroom work, then, is one aspect of CNA duties that is often perceived to be merely a physical ADL, but that has very real emotional consequences – uplifting the resident to the level of humanity they deserve.

“I like them to look good.” – Dressing with Dignity

In institutional settings where it is rare to have enough time to engage in long, deep conversations to determine the client’s emotional state, caregivers depend on outward appearance to both gauge a client’s feelings and to demonstrate their dedication to improving the patient’s quality of life. One smile from a patient can be worth a thousand words to a caregiver. When caregivers
see a client reduced to a disheveled, exposed state, they feel it is their responsibility to armor the client with the physical and emotional protection of clothing. Recall Grace’s experience seeing her father naked on a hospital bed in Jamaica. She was outraged that they would leave his body exposed. To her, clothing was a shield of protection; a neat appearance enhanced self-respect.

Along with Grace, several other caregivers explained that dressing the client carried emotional significance. Caregivers perceived that dressing in everyday, nice clothes preserved dignity for the client and indicated that the client was not giving up on life; that s/he was still an adult who cared about his/her appearance. Carrying on the theme of neatness, readily available fresh clothes also provided a cover just in case the client had a bathroom accident or a spill – issues not normally associated with independent adult behavior.

Though I recruited Beverly at an in-service meeting at a home care agency, she works full-time in a nursing home as a CNA in addition to her home health responsibilities. Beverly had strong opinions about the nature of nursing home work and her answers skewed towards addressing the challenges of working in that context. When asked what she liked about each of her jobs, however, Beverly focused on the rewards of dressing her clients well in the nursing home. Launching into an extensive discussion about how and why she
likes her patients to “look good,” Beverly articulates that being well dressed and having clothes readily available in case an accident happens provides self-esteem for the client:

Beverly (Jamaica): I don't know. For me, my patients all of them, although I have ten patients, I like them to look good. Until I dress them, everybody says they're not looking good. You know, sometimes I have workers in the nursing home tell me, “You take care of those patients just like it’s your mother and your father.” But I don’t care; they have to look good for me. That’s how I do it.

Megan: What would you describe as the most important part of your job?

Beverly: The care, to take care of a patient and see that they look good. If I look good, I want to see you look good too. Especially if you have clothes. But when they don't have clothes, sometimes I see some of the family members come and they say I shouldn’t do that. I tell them to bring some clothes for her. I've seen when some of them say they don’t have clothes. When I see family come in I know I'm going to have them. When I have them, they have to have clothes. And they have to look good. So when I see the family member I let them know, “Bring some clothes for your mother or bring some clothes for your father.” Because we dress them every day.

Beverly sees clothes as an extension of self for a person, and she makes sure that each patient has their own clothes marked to avoid washed clothes being misplaced. In fact, she thinks having enough clothes is so important that she ventures to tell clients’ family members to bring more than enough clothes for their relative to wear so that he or she will never be without a clean or fresh outfit to change into in the case of an embarrassing incident. She notes that her dedication to marking the clothes and encouraging family members to bring clothes builds trust with her clients and avoids the negative feelings she has
observed in the past when the client runs out of clean clothes.

Like Beverly, Ricardo takes pride in dressing his clients. Both caregivers remark that other staff members notice the attention to detail they put into making sure the clients look neat and polished. He explains:

Ricardo (Haiti): I’m here for thirteen years; I never got trouble with nobody. Patients come in, go and come from Assisted Living, when they are coming back, they are always happy to find me. I always try the best to make them happy when they come in here, and go happy and coming back happy. “Oh, I’m glad you’re still here, I still have you.” You know, the person at this age, they need love. They need attention. When you talk to them and then listen to them. When you come in, try to make them comfortable, try to make them do something too. When I do care, I always encourage my residents. “Here, try to help me, brush your teeth and shave yourself.” Make them do something, make them comfortable. I don’t want the residents to suffer. I’m happy to get them nice and clean, dressed, nice and...when I’m not here everybody knows! When I’m not here, everybody...even kitchen, therapy, activity, knows. “Oh, Ricardo is not here.” That guy, that person is dressed not too well, because Ricardo is not here. That’s the way I feel. When I finish dressing my patient, I want to feel comfortable with them.

In addition to communicating with the clients and encouraging them to help themselves with daily tasks, Ricardo views dressing the client as an important component in keeping the client comfortable. Similarly, Mercy sees value in her dedication to making the client look nice through dress and the hairstyling services she offers at the nursing home. She believes a nice presentation of self keeps both the client and his or her family happy:

Megan: What makes you good at your job?
Mercy (CNA, Nigeria): Good. How can I put it? I don’t know when you see somebody that is nice it’s just you look like … Sometimes the girls say to me, “Are you crazy out of your mind? Do you want to dress these people to look just like you?” And I try to do that but some of them…You just come and you know what you’re supposed to do; you do it. You know what makes your patient happy and you do it; what makes their family happy and you do it and do extra more for them. I do some of their hair two times a week.
Megan: Their hair?
Mercy: For free.

While clients can bring some of their belongings to nursing homes and assisted living facilities, they will never be able to recreate all of the sounds and comforts they left behind in their own home. These certified nursing assistants and home health aides try to maintain consistency in daily care to make the residents as comfortable as possible in a new setting. For caregivers like Beverly, this means bringing in (and marking) the clothes the client is comfortable wearing. To Mercy, offering a free hairstyle is a special treat that keeps her clients and their families happy and shows that she is going the extra mile in providing care and treating the resident how she would treat a family member.

“If you know the residents, you have no problem with them.” – Feeding, Checking In, and Anticipating Client Needs Before They Ask

At times, the structure and rigidity of nursing home schedules provides an opportunity to establish a rhythm of care and a measure of consistency that enables caregivers to learn patterns and anticipate a client’s needs. Unlike the
fluid nature of home care and the instability of losing a client to hospital admittance or a change in hours, nursing home work is relatively stable in that caregivers stick to an hourly schedule. When that schedule allows them to be in charge of a particular floor (as opposed to rotating assignments), CNAs start to develop an idea of when, what, and how a patient requires care. To be sure, home care agencies set guidelines for what tasks need to be accomplished, but as mentioned earlier, the autonomy of the home care setting can sometimes lead to more client flexibility and extra hours and demands on the caregiver. While there are drawbacks to set times for patient showers, meal times, etc. in that the client has less control over his or her care plan, Michelle’s case illustrates how repetition enables her to know what she needs to do and when she needs to do it. She also goes above and beyond to help other clients on the floor that she sees are in need:

Michelle (Haiti, CNA): What I love most in the job? To help people; to feed people. Sometimes, I am busy. Some patients ask me for water. I say, “I’m coming back.” After doing the thing I needed to do, I came back. They say, “Oh thank God, where did you go?” I say, “No, I never forgot you. I brought the water.” Some patient needs ice water, sometimes it’s hot water. Sometimes it’s warm water. Sometime they need a tissue. I give the tissue to them. Even if it’s not my resident, if I’m in the facility, I’m supposed to help patient. I feed some patients when I see they can’t feed themselves; they need people to encourage them to eat. We’re supposed to cut the meat. Some patient can’t cut...some meat is not well done. I’m supposed to cut, to slice for them. Open the orange juice; you put it in the cup for them. Don’t leave the orange juice; open it and leave it
like that. Even if they have no cup, go back and get the cup, put the milk in the cup, put the orange juice in the cup. I know what they need.

Like Michelle, Ricardo believes he excels at understanding client needs. He views himself as superior to other CNAs who merely complete the task without establishing any real human connection. Ricardo feels it is important to not only understand his clients’ schedules, but also to check in on them to see that their needs are adequately fulfilled. When asked what makes someone a “good caregiver” he responds:

Ricardo: Makes me good at my job? That depends. Some people, not everybody is the same. You find some people who don’t care. Just, “Ah, I’m finished with a person, I dry them, put them to sit down, that’s it.” They walk away. Me, the way I’m working is different, for me. That’s my opinion. If I finish with my patient, I’m always checking them every hour, every two hours. “You want to go to the bathroom? You want me help you go to the bathroom? Do you want something?” Any time I have a chance, I check. When I first come in, I know I have the guy who needs help to be changed. I don’t want the nurse coming to look for me. I know my job; I just go straight to put him to the bathroom to change him, because I know him. At 2:00, he’s supposed to go to the bathroom. If you know the residents you have no problem with them. You know exactly: at this time he wants help with something; at this time he wants something. Then you just do it. When I’m not here, the nurses have a problem with looking for somebody to fill in. When I’m here, I know, if it’s a quarter to 11, I already have him ready. If you know, you don’t have no problem. You don’t have no problem with nursing, you don’t have no problem with the supervisor, you don’t have no problem with the resident, because you know what to do, and you just do it. Then the patient is comfortable with you too. That’s why. It’s really important, to not let them suffer. Check them every hour, every two hours. And if they’re scheduled to walk, you have to walk them. You don’t have to wait till the nurse coming, “Hey, you’ve got to walk Mr. So and So.” No. You know what to do.
By trying to keep a consistent schedule and constantly checking in on the residents, Ricardo gives off the impression that every resident’s needs are valid and that he truly cares for their wellbeing. Even if it is as small as remembering that Mrs. Smith has regular bowel movements at 10 AM or that Mr. Jones attends the club every Thursday, Ricardo conveys respect for the client’s time and wishes.

Efie regards “checking in” and “keeping an eye on the residents” as the most important aspects of her job. She views that such behavior is essential to keeping the clients safe:

Efie (Ghana): The most important task of my job as a CNA is to keep my residents safe, as much as possible.
Megan: How do you keep them safe?
Efie: How do I keep them safe is like keeping an eye on them. Let’s say this patient likes to get up unassisted and she or he is not supposed to do that, we have to keep an eye...and before they used to have some kind of restraints, like an arm and stuff like that, but it’s not there anymore, so we have to keep an eye on them, like peek in their room and check if they are in the right position or...You know? Then keep checking on them like every fifteen or thirty minutes to see that they are safe. Let’s say if there’s water or something on the floor, you have to clean it up immediately so that doesn’t cause any kind of fall.

Even though these caregivers may not be able to spend hours in conversation with their clients, they glean information from their small exchanges and observations of their behavior and use what they learn to provide quality care and comfort.
CONCLUSION

Daniel: My vision...I think what I would envision is for the next...what I would like to see for the nursing home industry, I would like to see the nursing home industry change in a way that our members will be able to have a life, a better life that they don’t have to work two jobs. They will have some kind of pension when they retire that they can live on so they don’t have to live on just social security. I would like to see that they have health insurance and they don’t have to pay for it, and good health insurance – they don’t have to have the high deductibles.
I think the last piece I would like to see is...for the nursing home industry to have probably a staffing ratio where a CNA can have probably five patients or four patients. They can spend time with them; they can talk to them. So, that’s my vision for the nursing home industry, for the workers.

Listening, indicating respect, and preserving dignity for the clients are all important features of the reproductive labor performed by immigrant caregivers towards their clients. The caregivers tirelessly attempt to make elderly clients feel as though they are valued and that they are in control of something despite their physical and mental deterioration. While the caregivers may fundamentally disagree with the words or actions of the clients, they try to think of the best qualities of the client, the unique and special past that that person may have experienced. If they can bring some measure of happiness and peace back into the life of a lonely and dependent person, they feel as though they have succeeded. In an ideal relationship, caregivers perceive the kin-like connection with their clients to be mutually rewarding – not only are they filling the role of
absent family members in the U.S., but in some cases, caring for clients gives them the opportunity to deliver the love, attention, and physical help they would have wanted to provide to their own aging relatives.

Too often emotion work and physical labor are separated into distinct categories. For these caregivers, a soft touch, a refreshing bath, an extra check-in, or a thoughtfully composed question can have very real emotional consequences for the client. When time is scarce and emotional bonds are sacred, caregivers attempt to keep the clients comfortable and preserve dignity through the means they have available. Ultimately, however, caregivers regard a balanced combination of relational work and ADLs as essential to providing quality care. When they are hard-pressed for time, building the bonds they see as necessary to ensuring client comfort fails to be an easy task. And when they sacrifice time out of their own life to enhance the quality of life for their fictive kin, the caregivers’ own families may suffer the consequences.

Caregivers work long hours for little extrinsic reward in the form of salary or benefits as Daniel’s quote elucidates. To justify absence from their own family and to make the sacrifices worthwhile, caregivers depend greatly on the intrinsic rewards of building kin-like relationships with their clients and feeling the gratitude and love from an appreciative care recipient. As we will see in the next
chapter, when both intrinsic and extrinsic rewards are at risk, as in the case with a racially infused client-caregiver relationship or a xenophobic staff exchange, caregivers struggle to preserve their professional identity in the face of attacks to save face and continue with their job despite such challenges.
CHAPTER SIX: “Like a Dog in Their Backyard”: Racism, Xenophobia, and the Transnational Caring Self

Darline: Let’s say you’re working with ten nurses. You’ll probably find one who treats you like a human being, and the rest treat you like their dogs in their backyard. And I understand some of the patients. They’re like...

Stanley: Yeah, they have dementia and they have some issues –

Darline: Yeah, mental problems. Some of them, they are alert and oriented; they treat you like you are their maids. They don’t say please, they don’t say thank you, they just say, “I want you to do this. I want you to do that!” And then when you –

Stanley: Sometimes they say like, "Now!"

Darline: Yeah, they even say, “Oh, I pay you for that. They pay you for that.” It’s like, they pay you to be treated as a dog. I don’t like it. I don’t like it. Now I’m trying to go to school. I’ve had my green card for the last past three years, and I can go to school now. I’m trying to go to school so I can have a better job. I want to better my kid’s life. That’s the only thing I’m telling you is I don’t like it. I hate it. But I’m doing it because of my children.

Megan: So, you find that it’s upper-level management and nurses that are treating you poorly? And the patients, too?

Darline: Yeah. The patients, you can deal with them because...you learn how to deal with them. Some of them, like I told you, they have dementia, they don’t know what they’re doing. Some of them, they are alert and oriented; they really, really know what they are doing. They just want to treat you bad.

Stanley: They call you names. The F-word!

Darline: They can talk to you anyway they want to.

Stanley: And whatever they did, it’s the patient’s rights. Even when they slap you, they kick you...

Darline: Whatever they did to you, they’re right. They’re always right.

Stanley: You don’t have any right to say anything or do anything.

Darline: You learn how to deal with it. If they go off with you, call you names, you learn how to walk away from that. But when the nurses, the administrators, the Director of Nursing treat you like a dog in their backyard, this is something else.

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Despite the stories of love for their work and their clients that filled Chapter Five, many of the caregivers in this study encountered difficult moments that tested their patience, hurt their feelings, and at times, wounded their bodies. As Darline and Stanley attest in the opening passage, the barriers of skin color, ethnicity, and language emerged as very real obstacles specific to this group of dedicated caregivers challenging positive identity constructions and creating or reinforcing feelings of marginalization. Faced with discrimination by both their clients and their coworkers and employers, these caregivers struggle to find belonging, recover pride, and maintain a positive sense of self at work.

The strategies that these caregivers use to interpret and react to race-based abuse illuminate the complex relationship between race and immigration in identity formation and impression management. Previous studies have shown that upon encountering the black-white racial divide in the U.S. economy, black immigrants fight automatic relegation to the bottom of the racial hierarchy and the discriminatory consequences that accompany that particular social location (Waters 1999). Whether by highlighting their foreignness and perceived “cultural” strengths to distance themselves from stigmatized African Americans; calling on their “sojourner status” and relying on their transnational identity as their master status; or in some cases building solidarity with other oppressed
groups, black immigrants seek agency in shaping the perceptions held by other racial and ethnic groups (Kibria, Bowman and O’Leary 2014). Which behavior they choose depends on a variety of factors, including the amount of time the immigrant has spent in the U.S., their racial experiences in the country of origin and the strength of their ties there, as well their class and gender status.

Dealing with racism and xenophobia in caregiving settings presents a unique challenge for contemporary black immigrants working in direct care. On the one hand, immigrants walk a tightrope between emphasizing their foreignness to distinguish themselves from stigmatized African Americans while simultaneously maintaining their image as “seamlessly part of the client’s family” as discussed in Chapter Five. On the other hand, leaving racist and xenophobic remarks unchallenged keeps the black immigrant caregiver in a situation that may be harmful to his or her emotional and physical health as shown by the literature on microaggressions (Morales 2014).

Such delicate identity work in the face of discrimination is not limited to the caregiver-client relationship. Interviews with caregivers working in institutions such as nursing homes, assisted living facilities, and continuing care retirement communities reveal a challenging environment for immigrants of color working in the lowest level care positions under primarily Caucasian
nurses, doctors and administrators. Indeed, throughout the interviews, institution-based caregivers were more outspoken and visibly upset about racially-motivated incidents with coworkers than those that shaped the caregiver-client relationship.

This chapter explores the role of work and caring context on caring identity formation and showcases the divergent ways these caregivers tackle prejudice when it emanates from their clients versus from their coworkers. It develops the concept of the “Transnational Caring Self”: an extension of Clare Stacey’s (2011) examination of the “caring self” in her pivotal work on the experiences of home care workers in California. Stacey investigates how home care aides create a positive identity and “achieve the caring self through three types of identity talk: professing their care as natural or innate, emphasizing service to others, and drawing boundaries between themselves and ‘uncaring others’” (Stacey 2011:107). These three techniques are facilitated by the home-based setting of the work and fictive kinship bonds between the client and the caregiver, which suggest the work is informal, and the worker is by nature, altruistic. Through a parallel exploration of home care work and institutional care work by workers that have experience in one or both settings, this chapter elucidates the importance of context and exactly how the minimal autonomy,
understaffed shifts, and tense coworker relations that characterize institutional care settings threaten positive identity creation. I find that despite the threats to the caregivers’ identities, these black immigrant caregivers understand their value as filling the emotional voids for their clients and filling the material needs for their aging relatives and other family members abroad. This transnational orientation provides these caregivers with alternative identity strategies that help them save face and preserve their pride as “caring selves” when they encounter oppressive situations.

With clients, caregivers attempt to overlook racism by ignoring and excusing verbal and physical abuse in order to maintain the close familial bonds they view as central to the caregiver-client relationship. In particularly hostile situations involving clients, agency interference in home care settings and shift reorganization or team-based care designs in institutional settings can occasionally provide the caregivers with a way out or a measure of accountability against false charges of stealing, for example. When encountering racism and xenophobia on behalf of coworkers, however, these caregivers highlight the very source of criticism – their foreign-born status – by drawing attention to their unique personalities and pasts that they believe contributed to their caregiving excellence. In other words, they call upon the sacrifices they
make for their own families in the countries of origin, their tumultuous career trajectories, and the storied upbringings that produced the skilled, caring workers that they are today. Embedded power hierarchies in institutional settings create difficult environments whereby caregivers must balance the desire to challenge the administration and risk losing their jobs or let the discrimination go on while their sense of self diminishes. By drawing on the identity of the “transnational caring self” these caregivers realize their value and persevere in the face of marginalization.

**SPIT, SLAPS, AND SLURS: DEALING WITH ABUSE BY CLIENTS**

Veronica was called a “cheap prostitute” and a “cock sucker” by a former nursing home resident. Junior had a knife pulled on him by a home care client, a woman who he continues to care for to this day. Myra was cursed at, told to go back where she came from, and asked if she swam to get into the United States. Several of the caregivers in this study were baselessly accused of stealing the belongings of clients. As black immigrants, with the additional barrier of language difficulties (particularly for the Haitian subset), racist and xenophobic behavior from clients compounds the emotional and physical difficulties that already characterize direct care work for caregivers of any ethnic or racial background.
While other scholars have noted care work as a field of work fraught with race, gender, and class divisions, few have looked at the specific ways black immigrants navigate the racial climate of care work that depends on emotional kin-like bonds between the caregiver and the client (Berdes and Eckert 2001; Duffy 2011, Ryosho 2011). As explored in Chapter Five, caregivers in both home and institutional settings strive to fill the void of the absent family member by practicing emotion work in addition to performing the activities of daily living – both integral to providing quality care. When there is a threat to the desired bond, these caregivers interpret and react to maltreatment by attributing it to factors outside of their (or their clients’) control in order to preserve the family dynamic and save face. To be sure, many immigrants come to the United States aware of its divisive racial history and prepared to experience and challenge structural racism in the workplace (Waters 1999). They tend to underestimate the degree of interpersonal racism they will encounter from their elderly clients, however, and are often taken aback by their clients’ language and behavior. The degree to which the interpersonal racism is shrouded in “colorblind” rhetoric or is more overt and combative also impacts if and how caregivers cope and continue to care.
The “White Woman’s Burden”: Colorblind Racism in Carework

Paid caregiving relationships have long been marked by racial and ethnic divisions between care provider and care receiver (Duffy 2011; Glenn 2010). Before the establishment of nursing home and home health work as a medicalized field, women from minority ethnic or racial backgrounds often performed domestic work in the United States for middle-class and wealthy white Anglo American families (Kibria, Bowman and O’Leary 2014). A pattern of ethnic succession has characterized the field of carework; beginning with female Irish immigrants working as domestic servants, followed by African Americans, and more recently, the field has been saturated with immigrants of color.26 Accompanying this succession, prevailing nativist and racial rhetoric inform stereotypes that infuse the caregiver-employer relationship. In the nineteenth-century, Irish immigrant domestic workers were labeled as “crude” and “savage.” The intimate nature of domestic service, together with these stereotypes, encouraged employers (white American housewives) to take on a

26 Unlike white women and Irish immigrants before them, African American women did not experience easy upward mobility into a different niche, and domestic work became essentialized as a black woman’s job. In other words, blocked from other sectors of the labor market due to their skin color, black women entered domestic service in large numbers and carework became a racialized niche – whereby domestic service positions were so saturated with African American women that the very sector itself became seen as a domain suited to the “natural traits” of black women. The Civil Rights Act of 1964 allowed for employment opportunities to be extended to African American women, who increasingly moved into other jobs to escape domestic service and its association with racial servitude (Kibria, Bowman and O’Leary 2014).
“civilizing mission” to “conquer and domesticate the foreign” by viewing their role as training and assimilating their workers (Kaplan 1998 as cited in Kibria, Bowman and O’Leary 2014:106).

Such an idea of “benevolent assimilation” in domestic work continues to characterize certain client-caregiver relationships, especially in the home setting, and particularly for caregivers possessing strong accents and English language difficulties. Informed by the misguided idea that the caregiver is inferior to the client by virtue of her or his ethnic or racial background, clients view such “teaching” as necessary and important. Take Nadine’s story for example.

Nadine, a refugee from a French-speaking region of Cameroon, has lived in the United States for close to seven years after political problems in Cameroon forced her to leave the country, and more tragically, her family, behind. She was a successful teacher in her native country, and transitioned into the field of eldercare at the advice and training of a Greater Boston refugee center – an occupational detour common to several of the participants in this study. Nadine received her certification as a Nursing Assistant through the Red Cross, but currently works in home care, performing home health, housekeeping, and personal care for her clients. Nadine is passionate about her work. Much of her passion stems from the strong relationship she builds with her clients in the
United States and the rewarding nature of the work when a client appreciates her essential help. These positive bonds take skill and perseverance, and at times, fail to form despite the efforts employed by the caregiver. Nadine recalls one particular troubling relationship with a client; a relationship overshadowed by xenophobia and hostility:

Nadine: I have four clients. Three of them, the relationship is very good. They are really grateful they have somebody for helping there. They really appreciate me. They like me. They want to me to be working for them. But I have one client...she is so difficult. She is so rude to me. She calls me all sorts of names but surprisingly when [the agency] asked her to fire me she said, “No. I want her.” And they said, “But you are so unhappy with her.” She said, “No. I want to be able to teach her how to take instructions.” Finally we...I just got to think maybe she needs me for her own ego so I just let go. That woman is going to talk forever.

Highlighting other positive client-caregiver relationships slightly facilitates Nadine’s ability to overlook the abuse and name-calling by this particular client.

Despite these auxiliary strong bonds, however, Nadine struggles to cope with feeding her client’s “ego” and she exerts a great deal of energy in battling the negative feelings. Even when she tries to convince the client to take on another caregiver, Nadine is trapped by the client’s desire to “teach her how to take instructions.”

As discussed in the previous chapter, the emotion work of providing a client with some measure of dignity or independence to compensate for other
physical and mental declines is a prevalent strategy used by caregivers to accommodate a vulnerable elderly client. Nadine attempts to overlook her client’s prejudices and view such outbursts as an outlet for her client’s frustrations. Ultimately, Nadine frames the experience as one that reflects her emotional skill and her ability to cope and succeed in her work.

Nadine’s perseverance is also enabled by the notion that she is one of the only caregivers who can withstand this difficult client, a point consistently driven home by the agency’s coordinator. As will be discussed in more detail later, the agency, while serving as a useful buffer to the complaints and abuse that private market domestic work fails to have, views its primary role as catering to the senior citizen client population. Racism and xenophobia disguised as benevolent assimilation may be overlooked in order to keep the client’s care needs covered without service interruption. Small wins such as the agency siding with Nadine over an instance where the client demanded an extra hour after a shopping trip took longer than expected due to inclement weather, are eclipsed by encouraging Nadine to stay on the job:

Nadine: She calls me all sorts of names. “Oh in your country they don’t do this. You can’t even read. You can’t...” I don’t know. I said, “Miss, you don’t have to have me. Somebody else can come.” “No. I want you. You are honest.” I said, “Why are you shouting at me all the time?” Then, it’s like you know, she likes to do it.
Megan: How do you deal with that?
Nadine: It took me some time to try to figure out because she doesn’t like the service. I said, “Okay. I don’t have to be here. Somebody else is going to come.” She said, “No. I want you.” [The agency] said that nine persons have gone there. The client knows that I’m like her best bet so she doesn’t want to let me go. Then she has to say those things...I don’t know what. She needs to say them to somebody and it happens...it’s me. I can take it, then I just say, “Okay.”

The suggestion that Nadine is the only caregiver successful in “putting up” with the client, allows Nadine to feel as though the attacks are not personal, but that the harsh words reflect the client’s own deficiencies. While framing Nadine as “coming to the agency’s rescue” provides her with a coping mechanism and instills a measure of pride, it also places more responsibility on her to please her agency and stay in a bad situation.

Although this particular client demonstrates an ugly mix of both racially overt and “colorblind” discursive strategies, Nadine’s story is indicative of how calling out perceived cultural differences appears more palatable and easier to ignore than race-infused rhetoric in today’s “colorblind” society. Today, overt displays of racism are often overshadowed by “colorblind racism,” or the usage of divisive rhetoric that ‘refer[s] indirectly to racial themes, but do[es] not directly challenge popular democratic or egalitarian ideals’ (Omi and Winant [1986] 1994:120). Among other frames, attributing the consequences of structural racism to cultural deficiencies is a particularly pervasive technique that denies
racism as a force impelling inequality. Given that one of the strategies to
differentiate themselves from stigmatized African Americans involves
emphasizing their “cultural differences,” xenophobic comments on behalf of the
client present a difficult situation to navigate for the black immigrant caregiver.
Indeed, in the caregiving situation where fictive kinship calls for a seamless
incorporation into perceived family caretaking responsibilities, caregivers must
straddle the line between emphasizing their cultural strengths of caregiving
while also assuaging the clients’ concerns and biases against outsiders. Thus
despite claims that race and ethnicity do not impact the caregiver-client bond,
stories of cultural discrimination from the caregivers do not differ that largely
from stories of the past.

Overt Racism: Interpreting the Abuse

It is the prevailing nature of colorblind racism that makes overt displays
of racism seem most jarring. Given the overt racism happening in a “colorblind”
age, shocked caregivers find new ways to interpret racial and ethnic-based
attacks to maintain positive identity constructions and continue working at their
jobs. To save face in an abusive situation, then, a seemingly personal racist or
xenophobic attack was re-interpreted in ways that redirected abuse as stemming
from motivations outside of the personal relationship between caregiver and
client. As Stacey (2011) found in her work, the initial reaction from caregivers often involved “othering”: an identity strategy that involves the caregiver presuming his or her own ability as superior to other caregivers. As disillusionment sets in and the strained relationship persists despite efforts to “do the best they can,” caregivers resort to other strategies, which include: understanding the abuse as a consequence of age-related medical problems or interpreting racism through a generational frame. Attributing race-related abuse to factors beyond their control allows these caregivers to maintain confidence in their skills of emotion work and cope with clients’ behavior by ignoring comments, making light of such instances with humor, or calling on faith to help them practice patience.

“But I’m Different”: Othering

The direct care workers in this study created positive caring identities through self-talk that reinforced confidence in their abilities. This was achieved by comparing their skills and motivations to those of other real or imagined caregivers. Other caregivers who were described as only “in it for the money,” rushed with their patients, and impatient with “difficult clients,” served as the
foil to the caregivers’ ideal versions of the “caring self.” These CNAs and HHAs positioned themselves as superior caregivers who worked tirelessly to provide their clients with quality emotional and physical care. Cassandra, a CNA and HHA at an assisted living facility, describes her technique when meeting with new clients:

Cassandra: The way you do it...because you cannot go to somebody’s house and say, “I’m going to give you a shower. Go to the bathroom.” You have a way to do it. You have to – I’m different. Sometimes that’s why I don’t like to rush people. I like to give you time when I go there. I really like to sit down first, talk to you, and make you laugh. And then after that give you a shower because I’d like to give you like more time. Everything, you have to do it. I like to put you in the bathroom, give you time if you have to do something. Because I saw some other CNAs...they like rush.

Building trust and emotional bonds with her clients are central components to what Cassandra believes makes her a good caregiver in relation to others who “rush” and fail to build that familial bond. Farah also utilizes this method of emotion work, but feels that it was only after her client went to a rehab facility and experienced other “uncaring” caregivers, did she recognize Farah’s value:

27 A majority of the participants emphasized that they excelled at their job because they weren’t “in it for the money” but rather because they felt real emotion and responsibility to care for their clients. As we will see later in this chapter, this identity technique was often threatened by tense work environments created by coworkers and employers. Taking attention away from the intrinsic rewards reaped between caregiver and client, unhealthy coworker relationships elevated the importance of financial remuneration – shifting the focus to the importance of the job purely for survival and the desire and need to support one’s family in the country of origin.
Farah (Haiti, HHA and CNA): When [my boss] has a troublemaker, she calls me: “Farah, I know you can do it. You can do it!” I have one. One year, about one year with this client. I think this is the first time she’s had a person that has stayed for one year. When I start to feel hurt, sometimes I cry. I cry. Every day, she makes me sad! I have to cry before and sometimes I say, “God I need a job. She needs me, I need her.” I cried, but now, she’s my best friend.

Megan: Now she’s your best friend?
Farah: She’s my best friend. For the holidays, she has a daughter who gave me a card. I was very happy and she said, “Thank you for your patience with Mom.” They know she’s not easy. Now she’s my best friend!

Megan: What made you so sad in the beginning? What was she doing?
Farah: You try to be nice, but she talked to you like this, like that. [I would ask,] “What do you want to eat for breakfast?” “Why do you ask me that?” Oh, she was very difficult; she knows what she wants right now. After a while, she spend one year, I don’t know, because she went to the rehab. I don’t know if she saw the difference before between the worker at the rehab and me. When she comes back, she’s a new, new person.

Although Farah calls attention to her practical need for a job, she also notes the reciprocal reality that her client also needs her, which distances Farah from other caregivers who are only in it for the money. Like Nadine’s rationale, Farah also takes pride in the notion that both her boss and her client’s daughter recognize her patience and see her as the only caregiver who can handle the situation.

Like Farah, many other caregivers frequently utilized the frames of othering and altruism upon first encounters with clients considered especially “difficult.” Emphasizing his tireless work ethic and selflessness, Samuel explains:

I do anything now. I’m always a tireless worker and always ... that’s my
Samuel is convinced that his personality, hard work, and genuine compassion will directly alter his clients’ perception of not only him, but also of the agency where he is employed. In the institutional setting, Ricardo echoes similar personality traits that he believes elevates his status as a good caregiver in the eyes of both his clients and his coworkers, explaining that he “is different” because he goes above and beyond what is expected of him to check on their wellbeing. Although the execution of emotion work is different for Samuel and Ricardo whereby Samuel attributes his excellence to relational skills and Ricardo to anticipating the physical needs of his clients, both caregivers see themselves as going beyond the “call of duty” in their work. They attribute their behavior as stemming from their personality, specifically their “tireless” work ethic. To be
sure, both men called attention to their acumen in other jobs throughout their interviews, specifically Samuel’s business and management skills and Ricardo’s prior hospital training in Haiti, but both saw care work as an opportunity to exhibit and extend their “natural” skills.

Grasping for more agency in the client-caregiver bond, then, several of these immigrant caregivers practiced “othering” or essentially believing that their expertise and kindness was superior to other caregivers and would change the perspective of the client towards them, or on a grander scale, towards individuals of African descent in general. For abuse from new clients, specifically, portraying oneself as an exception to past “uncaring” black caregivers provides them with some semblance of control or hope that the relationship can evolve into a pleasant one - that race may be an initial factor, but hard work will eliminate it as a variable in that particular relationship.

Michelle’s story exhibits this sense of optimism:

Michelle: The CNA job. I thought it would be easy. When I go on the job, I say, “God, give me strength to do that job because it’s not easy.” You are supposed to have patience with the resident and compassion too because somebody goes to school, they are a doctor, they are a - whatever they are, they are a big shot. The sickness is coming on the body, his body. You’re supposed to have compassion and patience for the resident. Sometimes, they tell you the bad word, they don’t mean that. Yeah, bad word. They talk bad language with you because if the resident has compassion they’re not going to tell you the bad word. You have to take care of them; you should have compassion to the
resident and kindness to do that.

Megan: Kindness?

Michelle: Kindness, yeah. That’s why sometimes, some residents like me because I obey anything they said to me, I just do it. Somebody might sometimes be angry; they’re going to me, “You don’t do that!” because they don’t know what they do. A kindness: you listen, you do the job kindly. It’s the job. It is the job. That’s why I try to be kind and nice to the resident. I ask God all the time to give me patience. Sometimes people said, “You let people use you.” No, I don’t let people use me. They’re smart too – you give people a chance...it’s very tough in America now. You give people a chance to be changed. You give people a chance to be changed. That’s why when you are working with the old people, sometimes I sit down with them. We’re talking with them, talking with them, nicely.

For Michelle, a CNA at a small-scale nursing home, compassion for the aged and the determination to relate and please their needs go a long way in changing difficult behavior. She notes that while other caregivers claim she is “being used,” Michelle is determined to build a bond and overlook the name-calling and harsh words. She relies on faith to help keep her grounded and she relies on faith in the idea that people can change. James, the RN from Kenya, also believes that he has the ability to alter the racist worldview of his clients:

James (Kenya): I think racism in the older generation has been there a lot. Over here, it’s real bad. In my country when you see a white person when they come to visit, oh they’re like a king; you want to know what’s about this person. Some people will try and steal from them of course: survival mode. But you see people are more interested in why this white person is here in our country and what they’re doing, or if they can give us jobs, or if they can help us go to the U.S., whereas in this country, it’s the other way round. That’s why I said all it takes is for them to trust you. Once they trust you, that color thing is gone. It flies out of their mind.
James attributes racism to the generation in which many of his clients were born and that all it takes is a foundation of trust and a close relationship to change a client’s perspective.

Although othering tends to be a useful identity strategy for caregivers – especially in the beginning of building a solid caregiver-client foundation – when bonds continue to be threatened by perceived racial differences and the relationship fails to transform, these caregivers often revert to medicalizing the problem.

“I don’t think if she was with it, she would act like that”: Medicalizing the Reasons behind Racism

When I asked Efie, a young Ghanaian woman who works as a CNA in a church-affiliated nursing home while also studying to become a nurse what a typical work day involved, she responded:

Efie (Ghana): Well, I like the residents with all my heart. I do my job with my...with love. I don’t do the work because I want the money or something like that, because working with the elderly is very hard and if you don’t have patience, if you don’t have love and caring, I don’t think it’s a good field for you to be in. Sometimes it’s tough because they can piss you off or they can do something. You know? You have to be patient and know that, because of their situation, and sometime even us, the young, if you’re in pain, you get so mean and stuff like that. It’s aging, so what can you do? I love my job, with no doubt. But they can be mean. Very tough!
Megan: How so?
Efie: Some people can even slap you, kick you, scratch you, and say bad words to you. Like this resident, whenever I go to her room, whenever she sees me, she
will start screaming, “Help me! Help me! Help me! Help me! The black girl is here. She’s trying to kill me! Help me! Help me!” Like if you don’t have patience or you are not doing the work out of love, you might say something back. But that’s not how it works. Or do something back. You know? You just have to ignore, and then know that is her situation, because I don’t think when she’s with it, she would act like that. Then if you take this person seriously, now you will cry your head off. You will say, “Oh my God!” You know? Sometimes it’s hard, but you don’t have to take it personal. Me? I don’t. My coworkers always say, “Oh, my God.” They always say I’m tough, but I…like even when people are mean and stuff like that, I don’t even…I always ignore. When people are in pain they get agitated and stuff like that. They become mean, but it’s not them.

To prevent the overtly racist and xenophobic comments from destroying her self-esteem and caring identity, Efie chooses to associate her patient’s behavior with illness. In other words, Efie believes that it is pain and possibly dementia or Alzheimer’s disease that is causing such outbursts and abuse. It is the only way she can ignore the behavior, treat the patient with kindness, and cope with her job day in and day out. In refusing to “take it personally,” Efie is able to preserve her sense of self and her identity as a kind, loving caregiver remains intact.

Fabienne, a Haitian woman who works as a CNA in the skilled nursing center of a continuing care community, also recalls a similar experience with the battle scars to prove it:

Fabienne: I start to work at 6:00 AM to 2:30 PM. When I’m coming I do what I have to do. Some patients are difficult. When they are difficult, they curse you, sometimes they spit on you. You see that mark? One of them gave it to me. Whacks my hand. But what I realize is that sometimes the same person who
does that to me, I say, “You’re not my mother anymore, when you did that to me.” And they say, “Oh I did that to you?” And then you saw that they’re not themselves. I never have a problem with the residents because when I see them upset I distance, I leave them be. Some people...I’m always there to help people. If you cannot do something I’m there to help you.

For a moment, Fabienne sees a threat to her emotional and kin-like bond with her disgruntled patient. When the patient denies accountability, however, Fabienne is quick to excuse the behavior as a result of illness. The brief setback is forgotten and the relationship, and Fabienne’s “caring identity” remain intact.

Unfortunately, Efie and Fabienne are not the only caregivers who experienced both verbal and physical abuse on the job. While correlating the verbal and physical abuse with Alzheimer’s and other debilitating diseases was more common if not more feasible in institutions such as skilled nursing facilities where patients tend to be more dependent, home care workers also practiced “medicalizing” the causes of racist remarks and physical abuse. Samantha, a home health aide from Haiti excuses mean comments because she associates aging with illness: “I like to help people. Sometime, you know, some people are bad but I don’t care. I like my job. Sometime, when you try to help, they’re just mean. I say, ‘I’m going to do my best to help you,’ but I don’t have problem with that because I know when you’re old, sometime you got something.” Similarly, when I asked Stephanie, a home health aide from Haiti what she disliked the
most about her job, she responded:

Sometimes, when they feel bad, they begin talking bad to you. You are human, too. That’s the problem. Oh my gosh! Okay. You’re supposed to understand them but you’re going to hurt; you hurt sometimes. If they tell you something bad, they complain about the housekeeping people, the black people, that you don’t go school, you’re not this, you know? Some patients, they make you...but sometimes, I understand them because they’re old, they’re sick.

Stephanie went on to describe most of her clients as nice and helpful, but she is wary of being assigned future clients with dementia given a particularly threatening situation she experienced. One of her male clients often yelled at her and insisted on calling the police for breaking and entering when she arrived at his house since he could not remember who she was and what she was there to do. Rachelle, another home care worker, had a similar experience to Stephanie when she felt her life was at risk by a client:

Megan: So how would you describe the relationship you have with your patients?
Rachelle (Haiti, HHA and CNA): Depends. Some people are good, some are not. Sometime when you got a client – hey you got a client every day – one day she just looks at you and says, “I don’t like you. Don’t come back.” Or sometime for any reason, one day they just look at you, and they say “[n-word].” Some of them, the first time you come in she doesn’t want you to touch her. If I’m coming here to help you, how come you don’t want me to touch you? So when they say that or if you don’t want me to laugh, I have to come to office, I have to say, “Guess what?” Because she doesn’t like you, she doesn’t want you.
Megan: How does that make you feel?
Rachelle: If you say you don’t like me, hey, I said “OK.” But sometimes, hey the way you treat me, I feel bad, but not like too bad to hurt. I said, “OK, but I have to go to the office.” But sometime they are mental, yes. Sometime one got like
dementia, they’re trying to say they’re trying to hurt you, they want to punch you, to slap you, you know? I got some people who spit at me. So what you can do, because you can’t even do nothing. The only thing you can do is go to the office, let the office know… Sometimes when you have to do something they say, “Go! Go! Outside my house!” Sometimes if you say, “Can I use your phone to call the office?” “No, no if you touch my phone I will call the police on you!” You tell them what you have to do and just say bye.

Although both Stephanie and Rachelle had to lose clients and with that, an important source of hours and income, they resorted to seeking the agency’s help and the clients were assigned other caregivers. In this case, although Stephanie and Rachelle stepped into the roles of the “others” who failed to cement a nurturing client-caregiver relationship, they were able to attribute the situation to severe dementia and focus on the positive relationships forged with other clients.

Coping with Abuse: Saving Lives and Saving Face

Stanley: What can I do? This is my color. I’m very proud of my color.

“Unless you’re Michael Jackson!” Darline’s son, Claude piped in with laughter in his voice. Claude was sitting nearby during the interview and provided occasional assistance with particularly difficult Haitian Creole to English (and vice versa) phrase translations when prompted for help by his mother. He was largely focused on his Gameboy until the topic turned to race
relations that his parents faced at work. The levity Claude added to the
conversation quickly dissipated when Darline and Stanley began detailing
several very real and upsetting racial incidents they experienced. Probably the
most outspoken on the difficulties of nursing home work and the
marginalization they faced on the job, Darline and Stanley openly discussed
racism they encountered at the hands of their clients and supervisors.\textsuperscript{28} Having
little faith in the administration to help intervene in tense caregiver-client
interactions, the couple finds that their best option is to “let it go” and “leave it
behind” when they punch out of work so that such instances fail to disrupt a
positive sense of self:

Darline: We need to have a good relationship with the client. You have to learn
and deal with them.
Megan: Learn and deal with them?
Darline: Mm-hmm. If you don’t know how to deal with them –
Stanley: It’s going to be tough for you.

\textsuperscript{28} Methodological variables likely aided the candor with which Darline and Stanley felt they
could discuss the negative aspects of their jobs. I received Stanley’s contact information through
a contact at the local service workers union chapter and upon my arrival to his home, his partner,
Darline, also a CNA, expressed interest in being interviewed alongside Stanley. Many of the
discontents expressed regarding wage compensation and marginalization are directly addressed
in union campaigns. Because I did recruit this interview through an administrative channel,
Stanley and Darline did not have to fear that I was “reporting back to the boss”, an issue I
perceived in several of my interviews taking place on-site, regardless of the interview room’s
privacy, informed consent, and my assurance that I was working separately from the agencies
and facilities. Being able to interview Stanley and Darline in their private home, on their terms,
and through the reference of a trusted peer (read, non-supervisor) also likely helped aid in their
comfort to speak freely about their myriad experiences, some positive, but mostly negative.
Darline: Mm-hmm. Like, can you imagine right in front of you, you’re trying to help someone and then she’s calling you a name like n-word, b-word – all the bad names in the world, in the books!

Stanley: Sometimes they beat you up; spit on your face.

Darline: You have to stay calm and deal with it. You have to learn to deal with it just the way it is. It is what it is. I’m here for my eight hours, and whatever happened at home, as long as you step up inside of the nursing home, you have to leave everything behind. Leave everything behind, and then when you punch out and step out of the nursing home, you take everything back. But learn how to deal with them.

“Dealing with it” was common practice among caregivers affected by discrimination. Many of the black immigrant caregivers were aware of the bleak racial history of the United States and felt that generational socialization influenced the state of mind of their clients. By tacitly accepting a client’s state of mind, the caregivers relinquished some effort in trying to change their clients and instead accepted differences and focused on doing the best they could at their jobs. By focusing on getting the essential tasks and ADLs completed, and recognizing that the client was a product of his or her environment instead of believing the behavior to be a personal attack, caregivers were able to save face.

Vanessa and Jenniflore, a home health aide and a certified nursing assistant, respectively, utilize these aforementioned strategies. Vanessa explains:

Vanessa (Haiti, HHA): I dislike when people aren’t nice. Some people do not...You try to be nice with them, you know? But they are grumpy...Some people are racist too. They are racist, you know, like they don’t like black people. You know, everybody is not the same. He was born like that. He doesn’t like
you, you know, you have to...I don’t have problem with that, you know. I mean I try to...I like to make people comfortable. I like to feel comfortable, you know, but even...He may have some problems, you know, about the color. I can’t blame people for that. Everybody is not the same. We’re different in mind and...

Megan: How do you deal with that?
Vanessa: I have no problem. Yeah, I’m patient, you know? I’m patient with people. Everybody is not same. Everybody is not you.

Jenniflore (Haiti, CNA): Some people don’t want to be here and sometimes they take it out on you. No matter what you do for them, no matter how we act with them, they are always angry, they’re always mad because the place is not where they want to be. Some of them understood. Some of them, they have people who go for four years, they’re coming back. They’re asking for me! I’ve been surprised. I simply cannot believe it. They say, “Yeah, because you’ve been good to me.” But some of them – but what can you do? I saw them like...sometimes, like some of them called you [n-word]. Some of them call you, “Go back to your country.” But, what can you do? You come in to do the job. You give your kindness, your softness. You bear with them because they need you. You need them; they need you because they’re here for you.

Megan: How do you cope with the difficult people – the ones that don’t want to be here?
Jenniflore: You have to cope. You talk to them and you tell them, “I understand the way you are.” You bear with them because it’s not their fault when they’re not used to. They’ll put you down because you cannot expect everybody to be the same.

Megan: What’s the most important thing you do?
Jenniflore: The most important thing is you do your job. You came, you do your job. You keep the business clean, healthy. You do what you have to do. If you leave your house, and you came to work, you have to work. You do what they pay you to do. You keep the job the way you can keep your house. What you cannot do in your house, you don’t do it in the job. Respect yourself and then you make people respect you.

While attacks on their race and foreign born status admittedly bother both

Vanessa and Jenniflore, they try to prevent the comments from destroying their
self-esteem and confidence in their skills. Jenniflore, like Darline, focuses on doing the best job she can for her clients and she makes sure to highlight the positive relationships she forges with several of them – calling attention to racism as the exception rather than the rule. She does not view attacks as personal, arguing that only in respecting herself and believing in herself will she garner respect from her clients.

Refusing to feel belittled, attacked, and upset, many of the caregivers in this study attempted to devalue the power of racist and xenophobic comments and respond with lightheartedness just as Claude’s quip about Michael Jackson alleviated the dark mood in the room. In an uncomfortable situation then, several of the caregivers made jokes to the equivalence of throwing one’s hands in the air in exasperation that they were “born this way” and that they can’t “change colors” no matter how much they try. We learned in the last chapter that James is a frequent viewer of Comedy Central and uses comedy and humor to entertain clients and build emotional bonds. He also finds utility in humor when he encounters racism at work:

James: Now here’s the funny part: older generations, the way they grew up, there was a lot of racism, and you hear them saying the colored person or this and that or they’ll call you the N-word and all that, and I make a joke out of that. I go like, “Oh you know what? Actually I was born that way. Let me tell you, when you were growing up, that name got accustomed to us, but here we are.”
You try to divert the story and kind of knock it out and not get mad, it’s not going to help, you’re gonna’ go to jail over nothing.

In a situation where reciprocal hostility is never an option, James attempts to use humor as a release and a way to drop the topic from future conversation.

Veronica, a Continuing Care Community Activities Director from Jamaica, uses similar tactics:

Veronica (Jamaica, Activity Director): There are some and I think that’s a past thing that they definitely were like that; that they were prejudiced. We have two right now that tell you straight to your face that they don’t like black people. When she’s funniest I have to laugh because she’s...I think we have a better relationship now, but she’s always told me, she said, “I don’t like you.” Finally I was able to find out from her, I said, “What is it tell me? I want to know because I’ve never asked you that before. What is it you don’t like about me?” She said, “Because you’re black.” I said, “I’m so sorry that I can’t help that. I was born like that and I can’t change it, just like how you were born like that.”

When Veronica’s client called her names like “a cheap prostitute,” she felt her only coping mechanism was to laugh at the situation.

Using humor or dismissing the situation as out of the caregiver’s control allowed caregivers to cope with distress without disrupting the typical client-caregiver dyad where the client’s rights trump the caregiver’s comfort. To be sure, almost all of the caregivers in this study preferred to ignore abuse and actually saw their “patience” and “compassion” as qualities that made them exceptional caregivers. Indeed, several of the caregivers reported receiving
specific training through their agency or institution to teach them how to “deal with it.” These relatively passive-aggressive techniques served nursing home administrators and agencies well by minimizing conflict and maintaining caregiver-client continuity.

Though rare, instances where caregivers attempted to address client racism head on and/or educate the client did in fact occur with seemingly minimal consequence. Mirlande, a Haitian HHA and CNA, discusses her reaction and plea with her combative client upon an initial visit:

Mirlande (Haiti): She told me, “Are you new here?” I said yes. “Oh, I hope they send someone else here.” And she started yelling at me. And I told her, “I am here to help you. If you need my help, I will help you. But if you don’t I have to leave because I can’t let you yell at me for no reason because this is the first time I came to your apartment. I don’t know where your stuff is. I don’t want to go digging in your stuff to find anything. You have to tell me where I can find anything.” And she said, “Do you speak English?” I like smiling but I felt offended when she said that to me. But I learned to not take anything personal. What she did is discrimination. If I’m here, I know I speak English. If I didn’t speak English, they wouldn’t let me walk in here. And then I…she showed me where the stuff is, I did what I should do. And I walked out of her apartment and I came to the office and we put down what she said to me. And I told them, “Do not send me again to her apartment because the way she talked to me, that makes me upset.” But I could do…I could go farther with what she said but I don’t want to go that far. I just ignore her and keep doing my job.

Although Mirlande ultimately ends up reporting the incident to the assisted living office and “ignoring the situation,” she showed a glimmer of resistance in directly calling out the client’s language and treatment. James also feels the sting
of racism and xenophobia and attempts to challenge and educate the culprit:

James (Kenya, RN): This is something I have observed at work and we see a lot of this. I used to get so ticked off about it but I got over it. Skin color, because of the skin color, somebody would think you’re not professional or you don’t speak English. Somebody had once asked me, “Do you understand English? Do you speak English?” I go like, “Yes.” And I’m looking at them; I’m like are you for real? Another one has…they’d been sent over, and I’m on the med cart giving somebody pills. They pass and they go past me, they go to a person of a different color and they ask them. They go, “Why don’t you ask the nurse right here?” “Are you a nurse?” You know what I do? I pull out my badge, “I’m a registered nurse; how may I help you?” It’s breaking that barrier. One day, maybe, it’s going to be all broken but I teach my kids that skin color really doesn’t matter and never treat somebody different because of what they look like or who they are. You may never know. That could be the next president, look Obama.

James tries to subtly prove a point through his actions to entice people to reevaluate their stereotypes and stigmatizations. While not directly confronting the racism through discussion, he feels that handling the situation while also serving as an example of a successful, educated, black man will “break barriers” and educate people – both clients and coworkers - to change their line of thinking.

Thus, when the façade that racist behavior results only from mental and physical illness begins to fracture, and clients who are seemingly “with it” exhibit hostile behavior towards black immigrant caregivers, coping and maintaining a positive client-caregiver relationship becomes delicate work.
Beverly, a Jamaican woman who works as a CNA in a nursing home as well as a HHA in home care, explains the difficult negotiation in dealing with racism from dementia patients versus those “in their right mind”:

Beverly: I enjoy the most about the job when patients have manners; see some of them don’t have any manners. But although they don’t have manners you still have to take care of them, because sometime some of them is not in their right mind. Some of them are in their right mind and they know what they’re doing. But they are just racist, they hate you. They just look at you and hate you. You know, but you cannot turn back evil for evil. Sometime you will have to look in your mind and say you don’t know. Sometime I don’t know what’s going to happen to me and I don’t know who is going to be good to me. I don’t know who is going to be bad to me. So I just do good for everybody. Sometime some of them just say things about you. And you know, and they know you know it. Sometimes they’ll come and tell me that they are sorry. They never mean it.

Megan: Oh, they’ll apologize?
Beverly: Yes, some of them will...They just, I don’t know. Sometimes they’re just in their mind, the way they act sometime, they act as if you’re the one who let them get sick, you know, they just turn it on you.

Megan: How do you deal with people calling you names or being mean?
Beverly: You cannot call them names. You cannot call them names. But you have to tell them if they call you names, you have to let them know that they are wrong. Yeah, because some of them don’t respect you. And they think you are doing wrong to them, and you get disrespected. We need respect. We’re doing a hard job. Very hard.

Beverly’s decision to address racist remarks head on and “let them know that they are wrong” was a rare instance of resistance among the caregivers interviewed. While she emphasized that she practiced good care towards everyone regardless of their mental state, she refuses to let discrimination from the lucid pass by unchallenged. She makes it a point to address the matter
respectfully and without name-calling or other “evil” tactics. By addressing racial tension directly, Beverly believes the client-caregiver relationship will become mutually respectful.

Despite these small steps of resistance towards improved race relations, most participants fear retribution from employers if they challenge a client’s hurtful behavior. As the opening passage from Stanley and Darline’s interview exhibits, in the carework field, as in other service industries, “the client is always right.” In order to cope with verbal and physical abuse, caregivers develop other strategies to avoid marginalization seeping into their psyches and affecting their work. When ignoring, making light of the situation, and educating the client fail to work, and the intrinsic reward of “being the only one able to put up with the client” is outweighed by very real risk and danger, caregivers may resort to help from their agencies or institutions.

*When Having a Boss Helps: Mediating the Abuse*

Nadine, Stephanie, Rachelle, and Mirlande’s stories illustrate how home care agencies often serve as mediators in disputes between caregivers and clients. Being able to phone an administrator when a client becomes verbally or physically abusive provides a form of protection unavailable to domestic workers that are privately hired by clients directly. Although Nadine was
encouraged to stay with her condescending client, she could ultimately request a transfer if she met her breaking point, as Stephanie’s example attests.

Additionally, these home care workers are able to voice complaints (to an extent) to someone other than the client, providing an outlet for emotional and positive reinforcement of their skills in caregiving. Having “a middle man” and home base prevents isolation, but maintains the autonomy that caregivers crave when attempting to build better bonds with their clients.

To be sure, for black immigrants, and particularly black male immigrants who are regularly stereotyped as dangerous in everyday life, isolated home settings may be uncomfortable and unsafe work environments, even when the agency is a phone call away. I interviewed Felix, a sixty-nine year old man from St. Kitts in the office of the home care agency where he worked. He described the advantages and disadvantages of working in the home setting and compared those experiences to his work in mental health institutional settings. Unlike many of the other caregivers who had experience in both home and institutional settings, Felix articulated that he preferred working in the facility because he had the presence of supervisors and coworkers to account for his work and behavior:

Felix (St. Kitts): I’m a little bit different. I must say I’m a little bit uncomfortable in somebody’s home. Because I do not know if they will say they had something there and it is missing. They might misplace it. That’s my feeling. Somebody
else could be different, but I feel uncomfortable. As I say, what I find out is that some people, their mind goes and comes and they usually put things differently from where they normally keep it. I might be cleaning there and I might move it to a different spot and they might say it’s stolen when it’s not stolen. That’s why I’m uncomfortable there in somebody’s home, especially if they live by themselves. In the mental health facility, I’m fine. I love it there because most of them they cannot speak so I speak for them. I do everything for them really. It’s a much more comfortable situation for me because I have two or three supervisors there every day. There’s nothing really there to steal or move. Plus, my population that I work with right now are very low function level clients. They are actually – all of them are wheelchair bound. They cannot speak. If anything is missing, they wouldn’t know, but there’s nothing there to be missing because 95 percent of the time, everything is locked and the supervisor only has the key. If we need anything – soap, toothbrush, toothpaste, any extra clothes, we have to go to the supervisor. He has to open it and if anything is missing, it would have to be the supervisor because he is the only person that has the key. We cannot get inside there unless he is there and two persons always have to be there. Yeah two people have to be there if anything is coming out – if you’re taking out a soap, clothes, shampoo – it always has to be with two persons.

Although Felix knows he would never steal from a client, he prefers to have a structure in place that proves his accountability.

Like the mental health institution where Felix works, many of the assisted living facilities and nursing homes have built in mechanisms to prevent or diffuse tense caregiver-client relationships. Mirlande, a home health aide working in both an assisted living facility and out in the community echoes Felix’s views about the benefits of teamwork when race is a factor in the caregiver-client relationship:

Megan: So do you like working with another person?
Mirlande: Oh yeah. I do. Like, before yesterday, if I didn’t have another staff with me in the client’s apartment, she could call the office and say whatever she wants. You know, but I had one of them with me. And she asked her, “Does she speak English?” You know, so now she has nothing to say. She couldn’t say I lie to her or she didn’t say it. But I wasn’t alone, you see.

Mirlande also appreciates the rotation of shifts whereby caregivers have responsibility for different clients depending on the assignment.

Mirlande: They switch all the time. Even in the building, you don’t have the same client every day.
Megan: How do you feel about that?
Mirlande: That’s helped you learn and know them all of them. And that helps you make the difference between who and who. You know…like, you can see this lady I talked about earlier; I won’t go to her apartment. If she was the only resident living here, I would quit. But some of them, you went to their house, it’s like you went to your mother. “Hi, how are you?” They have big smiles. “Nice to see you.” And you do something and they’d say, “Thank you, come again,” you know. So some of them are good. Some of them – it’s a part of life. Yeah.

Efie also expresses the learning benefits of shift rotation:

Megan: Do you have the same patients all the time?
Efie: No. We move around to different, different floors. We float around. But we have a specific floor assigned to us each day. Let’s say when there’s too many people on that…on a certain day, we float around to different floors to help. You get used to different, different people and how they all act.
Megan: Do you like floating around?
Efie: Yeah, so that I will learn different stuff every day. I don’t want to be stuck in one place.

As Chapter Five attests, in ideal scenarios, most caregivers appreciated ample time to build bonds with individual clients. When faced with a difficult client, however, shift rotation in facilities presented an opportunity for relief from
racially sensitive situations. While home care workers often faced a drop in income from declining a client, institution-based workers had a built-in safety net to remove themselves from the situation while maintaining a consistent shift and wage. Teamwork and rotation also offered caregivers an alternate means of “caring identity” building in that they were able to expand the breadth of their knowledge by “learning” from a larger quantity of patients. This identity strategy is particularly useful in institutional settings where time pressures limit opportunities to practice relational emotion work and develop interpersonal relationships.

Several studies on domestic workers and the fight for unionization highlight the isolation and exploitation faced by caregivers employed in the private hiring “grey market.” For the caregivers in this study, both the agency and the shift structure of institutions act as buffers between the client and the caregiver, providing a safety net for caregivers to remove themselves from a dangerous situation or accusations of stealing. But like any other net, this safety net has holes – with countless cases of racism and xenophobia slipping through the cracks and putting pressure on the caregivers. To many of the immigrant caregivers in this study, addressing a difficult situation with management proved more fear-inducing and fruitless than ignoring the client’s behavior. This
avoidance is compounded by the fact that many black immigrant caregivers feel powerless in their jobs and surrounded by upper-level coworkers and administrators who not only fail to understand the consequences of racism but actually perpetuate and enhance it.

_When Having a Boss Hurts: Race Relations on the Job_

While caregivers excuse abuse from their clients by highlighting their positive identities as transnational agents of care and dismissing racist attacks as derivative of age, socialization, and illness, participants working in institutional settings tend to have trouble coping with racism and xenophobia from nurses and administrative staff. These caregivers often feel unappreciated and disrespected by their senior level coworkers, particularly the nurses and Directors of Nursing that work directly above them. They attribute maltreatment by the nurses as stemming from their race, language difficulties, and ignorance on behalf of their colleagues. Particularly, the absence of trust and constant questioning challenges the central positive identity formations of feeling altruistic and exceptional at their jobs. Indeed, consistent with Clare Stacey’s argument, the lack of autonomy in institutional settings inhibits the creation of “the caring self” as relational care is placed on the back burner and with that, the intrinsic rewards of caregiving are minimized. When these caregivers feel
marginalized and blocked from achieving upward mobility, they find other ways to uplift their “caring identity” and change their status in the eyes of the administrators. By emphasizing their skills prior to migration, expressing their desires for upward mobility, and suggesting diversity training for their coworkers, these caregivers utilize identity strategies that form “the transnational caring self.”

Set up to fail: Overworked and Overlooked

Many of the caregivers perceived their skin color and language barriers as directly impacting both their blocked mobility and hostile treatment from the nurses. Daily interactions with staff left them feeling dejected and misunderstood. These feelings largely stem from the lack of autonomy caregivers felt as “bosses always stood over them” and “made them nervous,” questioned their abilities, and assumed that they had no prior skills to bring to the table.

The chronic problem of being short-staffed placed extreme pressure on CNAs to fulfill multiple tasks in a limited span of time. With the added stress of having “the boss” watch every move, caregivers often felt marginalized and flustered. Yadira offers an example:

Yadira: Nursing home work is hard because you have to take care of about ten
or nine people at the same time and the nurses are behind you checking other things. They are so mean sometimes.

Megan: They’re mean?
Yadira: Mm-hmm. In home health, you are on your own. You have to do your work but it’s not the same where the nurse is behind you watching and you are doing everything like so fast. No. In a home, you can take your time.

Megan: You said sometimes the nurses are mean. How are they mean usually?
Yadira: They talk like they are your father like, “You have to do that.” They don’t ask you. They don’t say please. They don’t say thank you. Some of them are like that.

Feeling unable to adequately perform her job to her standards given the time constraints, the paternalistic and authoritarian presence of the nurse threatens Yadira’s caring identity. The following examples of Esther, Mirlande, and Fabiola echo Yadira’s insecurities. To them, the imposition of an overloaded client assignment and the refusal to assist the CNA to help ease the burden feels like an intentional act of malice by the nurses:

Esther: Uh, work is work. But, you know when you just go to a job, they left all the difficult people for you. You know, like they’re heavy, big, obese or fat people. Two people have to do it, but when they see that you are new, you don’t know. They try to let you do it all on your own. They don’t want to help when you just come. And you have to put help together to do the job.

Mirlande: And I don’t need anybody behind me when I’m doing anything. I know what I’m doing; I do it in a period of time when I’m supposed to do what I’m supposed to do. I don’t like people bossing me. They like to do this; they stand behind me and look what I’m doing. If I couldn’t do it, he wouldn’t let me do it. If you assign me to do something, give me the time to do it. And when I finish, see, come and check. Don’t stand behind me. Start here, start here, do this and that, I don’t like that. The job is not difficult, but sometimes, the people you work with make it hard for you. When I say the people, I don’t mean the
staff. Like the people who are over you, like the bosses. They make it hard for you. Their way, you know? Always looking over you or walking after you. I understand they have to supervise what you do but the way they do it, it’s like embarrassing. Yeah. So it makes you nervous.

Fabiola: In nursing homes you hurry with the patient. I don’t like that. You have to clean the patient. They don’t like to be rushed. When you do like that [slowly] the [nurses] say it takes more time. They complain for you. The nurses give your fifteen patients. Fifteen patients they give you only by yourself. Then they don’t help you. I don’t have the time to clean the patient. “Oh. You’re still there?” Uh, uh. Then they complained for me for no reason and then they fired me for no reason. That’s why I don’t like working in a nursing home. They don’t listen to you. The employees that are working with you. They complain about you. They say, “Oh she takes a lot of time with the patient. She doesn’t know.” Then [the administration] listened to [the nurses], but they don’t listen to you. They come and say she spends a lot of time with the patient. You say, “I’m not.” No. They fire you for no reason...No. That’s why I’ll never send my father or mother to a nursing home. No. I prefer to take care of my father and mother. I know the way. You have to sit the patient on the bed. “No. Don’t do it like that. Oh you don’t have time for that.” No, no, no. That’s not for me. Nope.

To these caregivers, spending ample time with the patients is necessary to enhance relational bonds and perform ADLs correctly. They feel set up to fail when they are assigned extra patients during their shifts. The attitude and complaints of the nurses compound an already tense situation. Given their lower level position in the nursing homes, Esther and Fabiola feel they have no recourse to protest the arrangement and view the structure as a fatal flaw in the institution-based care. Like Fabiola whose work experience now shapes her decision to “never send her parents to a nursing home,” Myra also believes that
the lack of compassion nurses have for the workload of the CNAs works to the
detriment of the clients:

Myra (Cameroon): Staff relations are not the best. Nurses and CNAs: “I have
this one, not this one, no.” You work for that facility, you don’t work for patient
A or patient B, you work for every patient. Sometimes you can call this nurse
who actually has the resident but they are busy with somebody else. Something
was happening to them; maybe they were having a seizure. If I call you and you
are busy with somebody else then I will call the next person. Don’t tell me, “I
don’t have that resident.” Go take care of the resident. Some nurses will be
telling you “Oh, I don’t have that patient.” That is it, they just sit there. That
could be your parent in there!

Stanley and Darline also express their disgust over the hierarchy between nurses
and CNAs and what they see as intentional behavior by the nurses to keep CNAs
“in their place”:

Darline: Do you know some of the nurses, if they don’t like you, they can –
Stanley: Make your life miserable.
Darline: Yeah you’re going to have to quit or... I don’t know. Because if they
don’t like you, and you have so and so, they will give so and so Maalox or
anything to make that person go nonstop!
Stanley: Ten, six, five times a day. Make your life – yup!
Darline: Yes, and then they feel happy about it!
Stanley: They can make your life miserable if they want to. Some... some nurses,
whatever you try to do for the patient to make them happy, it’s nothing for them.
No appreciation. That’s something that makes me feel bad. Frustrated.
Sometimes you can feel like it’s one of your best days at work. Even if you’re
working short, you try to do the best you can to get the job done, and don’t be
surprised, that’s one of the days you’re going to be in trouble. You’re going to
get a write up for something you didn’t even do. It’s tough.
Darline: Do you know that if the nurses, some of them know that you’re going
to school...
Stanley: They give you hard time.
Darline: They give you a hard time for that, too.
Megan: Really?
Darline: Yeah. Like if you go to school and you want to become a nurse... because they want you to be at that place all the time.
Stanley: To treat you the way they want. They don’t want you to come at the same level with them.
Darline: Yeah, they treat you bad.
Stanley: They can make your life miserable.
Darline: Yeah, especially if you go to school on weekdays and then you can only work weekends. They can even go to the manager and tell them not to let you work on the weekends.
Stanley: You remember that lady who was telling me? The one who went to school to become the nurse to find a job over there –
Darline: Yeah, she didn’t tell anybody. She didn’t tell anyone. She goes to school, she does her own thing, and then, oh my! She was working activities and she got into the nursing program and became an LPN, but they don’t hire her. They don’t give her the job. She had to find a job somewhere else. You know why? That’s what I think. I think, they’ve been treating her so bad, and seeing you pushing that cart, and they’re pushing that cart and then you’re pushing that cart, and you give them report, and you’re taking report from them –
Stanley: Yeah, you’re sitting at the same table with them. At the same level –
Darline: They don’t feel good. Because you are the CNA that they used to treat bad. Now you’re here, mm-mmm, they don’t feel good. So, I don’t know.

At first glance it may seem surprising that many of the caregivers continue to work in their field for years, given these horrific stories of sabotage and meanness. To be sure, while Darline and Stanley are actively trying to move out into general hospital work and up in position, many other caregivers find themselves toiling at the lower level of the hierarchy for most of their career.

Positive identity work is essential to surviving the marginalization they encounter at the hands of their coworkers. While their race and foreign born
status drives much of the prejudice and discrimination against these caregivers, this transnational social location is also what saves them from internalizing the negative comments and behavior.

_The Glass Ceiling or a Walled Border? Language Difficulties and Downward Mobility_

“I’m more knowledgeable than you think. Because I don’t speak the language doesn’t mean I’m stupid.” – Wideline (Haiti)

Many of the caregivers believed that the poor treatment they received from senior level staff stemmed from a place of ignorance. To them, the attacks, mistrust, and the lack of autonomy exhibited by the nurses related directly to the language barrier between coworkers and the assumption that “not speaking English” meant that a person was uneducated, stupid, and only capable of doing menial work at the CNA level. Daniel, who was once a CNA and who has since left his position to work for the local service workers union, illustrates this perception with evidence from his own experiences and observations of management in his current work:

Daniel: I think it’s the way how management treats my coworker, my fellow coworkers. I always… I remember I was… I used to be a delegate. There was a CNA, she did something wrong, and then the way management spoke to her, I feel embarrassed. I think the number one, I hate to use discrimination, that’s not
something I always…but I feel like this country – it’s a long way to embrace that kind of people: foreigners. And then when you have…people are not going to show you that, they may not see it, but discrimination, it still exists. We can’t deny that.

Megan: There’s like a racial and cultural divide?

Daniel: It’s more, hey, these people, they barely speak English. Management never sees them like kind of, hey these people – they work very hard. I think the other thing it’s more about is that you have CNAs; they don’t look at them as a human being. They look at them as someone that hey, you work here, you are a CNA – you did not go to school. I go to school; I’m an RN. I’m a LPN. I spend all my time but they don’t know that person came from another country. That person may have more education than you but they don’t see it that way. Speaking a language doesn’t mean that person is illiterate. If someone doesn’t speak English it doesn’t mean that person is illiterate. But all that being said, they have some good administrators, they have some good DON. I think many people I work with, especially DON and administrator, they have…some have a good heart. They have…some I know they care about the CNAs, but majority they are not. They have people…I don’t know. I don’t have a specific case, but I know for a fact they have some people who probably passed away or got sick or too much stress. Because when you are working in this country, you are an immigrant, you don’t have papers, you don’t speak English, and then you have a job, you have a house to pay, you have a car payment, you have to feed your kids, you cannot take all these crap from management because you don’t want to lose your job.

While Daniel is hesitant to call out discrimination for fear of being discounted as “playing the race card” he claims it is a major contributor to the stress and difficulties faced by black immigrants working in the field. He argues that management fails to see the caregivers as human beings, capable of having skills outside of work both prior to and during their tenure on the job. Although he recognizes that not “every” director of nursing holds prejudice and practices
discrimination, he sees a majority of management teams in need of diversity training and awareness.

Both Farah and Darline, immigrants from Haiti, have personally experienced their English language difficulties as getting in the way of their success. Farah was a nurse in her country prior to migrating, but since her credentials failed to transfer, she had to take a job as a certified nursing assistant:

Farah: It’s not the same thing because you have more pressure in the nursing home, you have a boss after you, and sometimes the coworkers are not nice. Megan: What do you dislike the most about your job in home care? Farah: When somebody isn’t respectful about me. Usually not the resident, but maybe the coworkers, the nurses. I have no problem with the patient. Megan: That must be frustrating since you were a nurse? What don’t you like? Farah: Sometimes, most of them were CNAs, too, before they become nurses but sometimes she thinks when you are CNA, you never go to school, you can do only this job sometimes.

Similarly, Darline emphasizes that her bilingualism and education are overshadowed and ignored by the fact that she has trouble with English. She argues that she is only working in such a menial position because her past skills failed to be accepted and that she needed to take any available opportunity in order to support her family financially:

Darline: We came here, we learned how to speak English; we speak French and Creole back home. We used to go to school like everybody else. We graduated high schools, and we go to college...but when we came in here, it’s like a fresh start, like kindergarten. You don’t know anything. You ... and you left family
back there, and you need to help them. You want to do anything to help them, but it’s not because we’re dumb. That’s what they think. That’s why I hate it.

Several of the caregivers found that young, white nurses were the most threatening culprits of discrimination. In their candid interview, Darline and Stanley noted that older nurses tended to be less hostile than the newer, younger nurses who acted entitled and superior to the CNAs that had been working there for years. Felix, the CNA and HHA from St. Kitts, also expressed disgust with new nurses dictating original care plans that fail to take into account the tried and true procedures that the CNAs had practiced successfully for years:

Felix (St. Kitts): My supervisors. Those are the most difficult thing to live with.
Megan: In both home care and at the facility?
Felix: No. These are okay but for the mental health institution, the worst are the people that are like this. Most of them, they do not work from the bottom of healthcare. They start like in the middle to the top and they didn’t experience what it takes for the job because 95 percent of them, they went college, they might come in the place for a week and then they go back to college and then they have their degree and they come back. When they come and they get a job and they ask you what’s going on and you try to explain to them, they’ll tell you, “No, that’s not the way to do it.” When it’s boiled down, they still have to do it the way that somebody told them because their way was the wrong way because they are going by the books and the knowledge that they know but they do not take it from the bottom. They take it from the top and go up. I just say they...that’s the worst: my supervisors. Cause they don’t listen to reality. They don’t listen to the people that are lower than them really. That’s lower than them. They might say, “Okay,“ and then tomorrow they might go put up something that we have to do, that the staff have to do, but still when everyone look over, they said, “This person cannot do that.” We have to call a meeting and tell them and we have to show them that this client cannot do it because if
they want to teach the clients how to brush their teeth and they cannot use their hand, how you going to teach them how to do it? They only care about the check mark in there.

As Felix attests, CNAs and HHAs perform the most intimate work with the clients. They get to know the clients – they understand their abilities, their progress, their needs, and their difficulties. When these caregivers feel confident in their relationship with the clients, but feel that they have no control over the care plan and that their suggestions are blatantly ignored in favor of textbook instructions, they see their value as disregarded and become frustrated. Because they feel “stuck” in this position without a clear path of upward mobility, these immigrant caregivers often highlight their past achievements in work and the sacrifices they make for their family.

Feeling disillusioned and upset about their work environment, then, marginalized CNAs turn to the idea that care work is a job that they accepted in order to be able to provide for their family members. In essence they are still maintaining pride in their sacrifices for transnational care, but isolating the job as only one facet of their being. Many times, men and women working in institutions highlight their prowess at jobs other than direct care in their sending countries. Take Mona, for example. She remarks, “I like working with people. The elderly, I started with my mother. But my vocation – it’s not in healthcare.
It’s because over here, it’s more practical, that’s why I jumped in the field – if I can find something quick to live my life.” Therefore by using the homeland as their frame of reference, black immigrant caregivers are able to maintain a positive identity formation that preserves what they consider natural caregiving talents, but that it is xenophobia, language barriers, and racism that holds them back from achieving their full potential (Arthur 2000; Rogers 2001; Vickerman 1999).

Highlighting past achievements and seeing caregiving as a learned skill rather than an innate calling was especially true for the male participants in the study. In other words, these caregivers viewed their work as a constrained choice given the structural barriers they encountered in the United States. Such identity work remains compatible with gender roles while also opening a space for men to create a caring identity where they can position themselves as superior to other caregivers. The men in my study were business owners, worked at the administrative levels of national government organizations, contributed to advocacy projects, or held government positions. Upon migration to the U.S., they were unable to continue on the same career trajectory. Most of these men attributed their acquisition of care work jobs to language barriers, particularly for the Haitian subset. They also lamented that their accrued
credentials and skills were not recognized by U.S. employers. Care work was then seen as a viable option in part because they heard about it through social networks of family members and friends who acquired work in the field. For example, when asked about his life in Haiti, Edouard, a home health aide responds:

Edouard: I was a statistician. The government – it was like a scholarship – I worked there and they sent me to study statistics. I spent two years studying statistics and I came back to work for them.
Megan: How do you feel about the transition from doing that to doing what you do here?
Edouard: I think that is life. In my country, I would never have done this job. If I was in my country, I wouldn’t do it…Because in your country you studied too much to do that. But here we have to do it because I have to study first if I need something like high level.

Thus, he perceives his job in care work as downward mobility from his professional position in Haiti. While in another part of the interview, Edouard notes that he helped provide for his family in Haiti, his informal care role was as the economic provider. He notes that paid care work in Haiti is an unskilled job beneath his social standing, but he recognizes that, as a black immigrant in the United States, he has to make a living and support his family, and that his foreign credentials fail to transfer to an equivalent position. Like Edouard, Samuel also positions himself as a “survivor” who had to take any job in order to survive in the United States. He explains:
Samuel: When I came here it was this source of disappointment since I was already well off in my country, owned my property, until now. Because now they do not have recognition of what you were over there so basically what happened is you’ve got to take any job; it doesn’t matter who you are. You’ve got to be a survivor, so any job. The first job I get in the USA was working as a dishwasher. Oh! That was humiliating! For me that was the feeling, but now I don’t mind, I will do it. At first, remember when you are highly educated in your country you know, based on our culture at the root of slavery, that means when they give you household work it means that they’re humiliating you. That’s why Haitians always have pride when it comes to school. Even if they work there, they are not going to stay there. They do it to survive and later they will be above. That’s how we do.

To make sense of this occupational detour into healthcare and build positive identities in the face of marginalization, then, participants practiced several strategies to defend their entry into a feminized field and preserve their sense of dignity. Their transnational social location facilitated the use of these strategies. This includes using the sending country as a frame of reference, whereby the participant’s identity as an immigrant trumped other identity formations (Waters 1999). Participants would highlight that they were working in direct care because they had to be a survivor and achieve the opportunity promised in the American Dream narrative. They emphasize the education and skills they have from their home country, but that structural factors out of their control pushed them into direct care.
These caregivers also highlighted that they entered work in order to fulfill their roles as fathers and sons for family members dependent on them in both the United States and in the countries of origin. Edouard, while underscoring how his job and free gas gave him the best life in Haiti, notes that life here is acceptable because he is able to support his daughters, no matter the profession. Upon telling me, “I miss the climate. I had a job. I work for the government, I had a car and they would give me the gas. When I lived there it was my best life. Here too I have a good life. I have a car, I work, I have money, my daughters go to college,” he proceeded to grin with pride and offered to show me several pictures of his daughters on his phone. Emeka echoes the point that his main responsibility as a man is to support his family financially by whatever means necessary. He explains:

Emeka: [In Nigeria] we don’t have facilities like nursing homes, pediatric homes. Any aging parents or aging whatever, stays in the family. The family takes care of that person and goes about their needs, goes about the medication, and stuff like that...Yeah, if you don’t have the money to pay for that kind of situation like this, I mean...That’s why we work so hard. Families work so hard and they do business to make sure they attack problems like this. If you don’t have that money for this kind of something, automatically that person will die.

Emeka goes on to note that, ideally, immigrants can use direct care as a stepping stone. In other words, he believes that care work is an easy job to acquire as an immigrant due to network hiring, but that it is not his true calling.
Emeka: Mostly that’s what we Africans do here, so once we come – I mean, you have to start somewhere and this is the first place. We start here and then you can, you know...If you have anything you have in mind to do...but first of all, we start here. Because the person you’re coming to meet here is in the job. The person you’re living with now is in the job. Everybody is in the job. I mean, it’s not a bad job. We start here as a stepping stone then before you can do everything you want to do.

Like many other immigrants in this study, Emeka has found himself working in direct care as a CNA for over a decade.

*Moving up and Moving Forward*

The stories in this chapter disrupt the illusion of carework as taking place in nurturing and peaceful environments. Despite the creative strategies employed by the caregivers to create positive identities in the workplace, remedying the unequal, hostile relationships should not be a burden for caregivers to suffer alone. Several of the caregivers expressed hope that with hard work they could one day move up from the position and out from the strain of being considered stupid, uneducated, and uninformed. Unfortunately, few have been able to break the glass ceilings that keep them in their position at the bottom of the hierarchy. Beyond identity work, concrete solutions must be proposed to alleviate discrimination and attain more amicable working environments.

Wideline, a Haitian woman working as a HHA in the assisted living
facility of a continuing care community argues that there should be diversity training for nurses and administrative staff. She believes awareness of the different cultures and histories of the nursing assistants and home care aides would go a long way in mending hostile relationships:

Megan: What do you feel is the most difficult part of your job?
Wideline: When you’re trying your best and for certain people, your best is not enough.
Megan: For clients?
Wideline: No, for...for staff, yeah. Yeah, because sometimes you don’t need a PhD to see...Yeah, and they don’t know your knowledge because you can read body language too. They underestimated you. Yeah, because they think, ah, because you’re a foreigner, oh, you’re from Haiti. Haiti is a nation. I’ve been...I mean, I’m more knowledgeable than you think – just because I don’t speak the language doesn’t mean I’m stupid. If I have to expose myself to tell you, what I know...what I’ve been through, what I’ve been doing, you’ll be in shock. You want to give them a glimpse what...who you are. They should provide education and communication because everybody is different. They could have some strategy to help each other.

Wideline suggests a forum for nursing home staff that would facilitate communication between people of different cultures and backgrounds. Respect and appreciation by the nurses and administrators could help increase her job satisfaction and maintenance of her positive caring identity.

Darline’s suggestion takes diversity training one step further. She argues that nurses and administrators should walk in shoes of the caregivers and see what their lives are like in the countries from which they migrated.
Darline: They are like evil. But you know, it’s...sometimes I will always pray to, I always say so one day, even though at their last minutes, they send one of the nurses or one of the bosses to Haiti to see where we live our lives. I would be happy. Because the way they treat you, I don’t know, because you do the CNA thing, they think that you are nothing. And I’m telling you; I swear to God, our lives in Haiti, I don’t know what to say about it. But if they see how we live our lives in Haiti, they would probably change their mind about how they treat people, especially the CNA. They treat you like garbage, like you’re nothing, like you’re dogs in their backyards. Not even all dogs. But some of them are so nice. They’re very nice. What else can do you? You got to do what you got to do to survive. You have to pay the rent and everything.

The pleas of both Darline and Wideline reflect the desire of countless other caregivers that administrators and nurses take a moment to understand their perspectives without making assumptions based on their race or their foreign accent. These caregivers work tirelessly to help their clients at work and provide for their families at home. When extrinsic rewards are minimal and intrinsic rewards are threatened by racial tensions and ignorance, the state of the care workforce becomes precarious. As Daniel suggests, the CNAs are the bonds, the “beast of the nursing home.”

Daniel: This is a great work but it’s just you have people, especially management, they don’t give these people credit. I’m not going to say credit but it’s more the respect they need, how they should treat them. They should know CNAs is the bonds...This is the beast of the nursing home. If you don’t have CAN, you don’t have work. But management doesn’t know that.

Without caregivers, who will care for the massive and growing aging population?
CONCLUSION: The Globalization of Eldercare

Through their experience caring for elders in the Greater Boston area and contributing to the changing environments of care in their sending countries, these paid caregivers act as agents of the globalization of eldercare. They bring values of love and respect for elders to their work in America, and to their aging relatives abroad, they send remittances of money and equipment along with new ideas about skilled medical care. These dual processes reflect how cultural globalization and economic globalization are grounded in the perceptions and practices of a set of actors (Appadurai 1990). Although their perceptions and practices are largely transnational in direction, taken together, the collective behavior of this black immigrant niche has far reaching consequences for countries across the Caribbean and Africa, and within the care system of the United States.

The transnational social location of these immigrants, whereby they continued to maintain social and economic ties to the countries of origin while becoming “simultaneously incorporated” into the social and political fabric of the United States, yielded rich evaluations on caregiving “best practices” (Glick Schiller and Fouron 1999). Seeing firsthand the reciprocal nature of physical and emotional health, these immigrant caregivers aimed to provide compassionate
holistic eldercare to their clients in Boston and their family members abroad. Their experience as paid caregivers for the elderly in the Greater Boston area engendered new ways of thinking about affordable skilled geriatric healthcare, while it also fostered scathing critiques of a system perceived to be too fixated on countable “tasks” at the expense of ignoring emotion work and the caregivers who provide it. On the other hand, these caregivers applauded the perceived “closeness” and interdependence of families in the countries of origin in relation to an atmosphere of isolation for elders in the U.S., but they recognized the limits of emotional support when medical emergencies transpired “back home” and medications, medical equipment, and skilled care were unavailable or too expensive.

Based on feelings of personal responsibility to care and their desire to “give back” to their families and communities in the countries of origin, these caregivers engaged in strategies to make skilled healthcare more accessible. Decisions on how and what to remit – whether they chose to send remittances directly to family members; develop plans to implement medical supply businesses or caregiving training centers in the countries of origin; or encourage aging family members to migrate to the United States – largely depended on their assessments of political climates. Although restricting transnational
activity to person-to-person remittances rather than top-down processes has the potential to create or maintain inequality by limiting the reach to social circles of the migrant, utilizing community institutions such as churches help “spread the wealth.” Additionally, since interdependence and communalism were upheld as two prominent cultural traits attributed across all of the sending countries, promises to share and care may provide more equitable economic and knowledge distribution with regards to geriatric care.

Guided by the perception that elders in the United States were lonely and isolated, these caregivers worked to establish fictive kinship bonds with their clients. In many cases, these caregivers conceptualized “the family” as one that extended beyond the nuclear form to encompass extended relatives, friends, and even other members of the community. Given this broad definition, the incorporation of clients as fictive kin was often seamless, and in several cases, mutually beneficial as it not only enhanced the wellbeing of the client but also provided caregivers with a space to imagine caring for their own parents and relatives who remained in the countries of origin. Since these caregivers perceived the U.S. as excelling in providing affordable medical care, they focused their efforts on delivering emotional care to their clients, through nurturant practices and assisting with ADLs in ways that preserved their dignity. Because
institutional care facilities were often structured in a way that conditioned Medicaid reimbursement on countable tasks, caregivers in these settings had to “get creative” with emotion work. Recognizing the emotional benefits of touch, attentiveness, and ADLs such as dressing and cleaning, these caregivers structured their care accordingly, and felt as though such practices improved the quality of life for the residents.

Despite their efforts to provide exceptional compassionate care to their clients in the United States, paid caregiving continues to be characterized by low pay and few benefits for the workers. Glenn associates the continued marginalization and devaluation of the field and with its classification as a gendered occupational niche, whereby “the pattern of women taking disproportionate responsibility for care is so well established that it is largely take for granted, often not noticed, and, when noticed, seen as natural” (2010:184). Indeed, these notions of caregiving as “natural” to women were often so engrained, and perhaps even enhanced by the complementary narrative of the “loving Third World culture, with its warm family ties and strong community life” that many of the female participants utilized this rhetoric to interpret their acuity as caregivers (Hochschild 2002:23). Positioning caregiving as distinct from “real work,” and viewing love and money as “hostile spheres” serves to justify
arguments to keep wages low (Duffy 2011; Hochschild 2002; Zelizer 2005).

The stories in this dissertation reveal caregiving practices that are anything but unskilled. Although these caregivers may identify their cultural background as providing them with the tools needed to excel at emotional labor, the tailored emotion work they provide for elders illustrates sharp intelligence, perceptiveness, and “a know-how and judgment, [that allows them] to make such judgments as well as possible” (Tronto 1998:17). These caregivers go above and beyond for their clients – staying past their allotted time to “keep company” with someone who needs it or performing a wellbeing check for a nursing home resident even when he or she was not on their assigned list for the day. The same individuals who treat their clients “like family” find themselves having to take on multiple jobs just to make ends meet and provide for their own family members both here and abroad. These efforts should be recognized and valued. Edouard and many other caregivers in this study believe that “if you have a good salary...people can give better care because they have a good salary.” They report feeling overworked and underpaid, forcing them to take on extra jobs that contribute to exhaustion and reduce family time. Even if they are fortunate enough to reap intrinsic rewards from fictive kinship bonds, it is still “real work.” It is important work.
Glenn (2010) posits the three goals needed to achieve a society where caring is valued:

(1) Caring is recognized as ‘real work’ and as a social contribution on par with other activities that are valued, such as paid employment, military service, or community service. (2) Those who need or require care (including children, the elderly, disabled, and chronically ill) are recognized as full members of the society and accorded corresponding rights, social standing and voice. (3) Those who do caring work are accorded social recognition and entitlements for their efforts similar to those who contribute through other forms of work or other activities. These entitlements include working conditions and supports that enable them to do their work well and an appropriate level of economic return, whether in wages or social entitlements. (P. 189)

To achieve these goals, then, care must be viewed as a public social responsibility and as “central to the rights and entitlements of citizens.” Under such conditions, those who perform caregiving would fulfill an obligation of citizenship and “are thus entitled to societal benefits comparable to those accorded to those fulfilling the obligation to earn (for example, social security, seniority, and retirement benefits)” (2010:188–90). To move beyond the arguments that devalue care necessitates a significant change in the underlying care logics that structure both the U.S. system of care and the care cultures of the countries of origin.

Rather than relocate all caring activities to public institutions or revert to traditional models where care took place primarily in the home, these caregivers
call for a combination of public and private care. Their desire to foster a balance between supplying skilled healthcare and maintaining close family bonds reflects the Warm Modern Ideal of Care articulated by Hochschild (2003):

The warm modern ideal of care...is modern because public institutions have a part in the solution and it’s warm because we do not relinquish all care to them. It’s also egalitarian because men and women share in what we do not relinquish. In contrast to the postmodern model, notions of need are not reduced or denied, so caring is recognized as important work. In contrast to the cold modern solution, it calls for fulfilling these needs, in part, personally. (P. 222)

To bring this form of care to fruition, Hochschild lists prerequisites that echo Glenn’s conditions. She argues that there needs to be a shift from a culture of individualism to a culture of care; transferring care to the public realm should be seen as positive; and caregiving must be professionalized whereby caregivers “need well-organized occupational groups to establish control over accreditation, monitor the entrances and exits of people from the field, and lobby for other measures to increase public’s appreciation for their emotional labor” (Hochschild 2003:222–3).

Both Hochschild and Glenn’s models recognize that caring for the caregiver is essential to producing a more just society. These theories and proposed strategies, while instructive for working within national systems, should be taken one step further given the prevalence of transnational
immigrants working in the paid caregiving segment of this field. Their “simultaneous incorporation” into two nation-states requires conceptualization of social protections and rights for caregivers at the global level (Levitt et al. 2015:16). Díaz Gorfinkiel and Escrivá (2012) explain how neoliberal structural changes at the state level forced families to adapt or activate new resources, spurring the phenomenon of transnational families. They argue that “states, in turn, have to include this global reality in their understanding of social rights if they are willing to maintain certain living standards and social cohesion (2012:139).

While changing the logics behind care cultures are large-scale and long term goals that require both states and individuals to subscribe to its tenets to be successful, the stories of these immigrant caregivers reveal smaller, more attainable objectives that can be achieved in the interim. To address the imbalance in nursing homes that rewards the “high volume of instrumental acts” at the expense of emotional care, Jason Rodriquez suggests that nursing homes “should promote functional independence and wellness and should be rewarded for that…the reimbursement structure should be changed to improve nursing home quality by restructur[ing] Medicare and Medicaid to reimburse facilities for value instead of volume” (2014:158). He cites the Patient Protection and
Affordable Care Act which “rather than reimburse on the basis of the amount of
therapy and daily assistance provided to residents, Medicaid and Medicare
could pay more for better outcomes such as lower rates of pressure ulcers and
better staff-resident ratios” (2014:158). Given the criticisms levied by these
caregivers towards the chronic problems of under-staffing in nursing homes, this
change would likely be celebrated. More time with patients would allow them to
devote more of their energies to the relational acts of emotion work, while also
being able to provide important medical care to their clients.

In addition to changing the structure of Medicaid reimbursement, changes
need to be made at the institutional level to improve work environments,
particularly with the goal to foster better relationships throughout the nursing
hierarchy. As discussed in Chapter Six, caregivers working in eldercare facilities
were deeply troubled by the perceived racism and xenophobia they experienced
from nurses and other upper level staff. Recall Wideline’s suggestion to provide
inter-staff education and Darline’s recommendation for the nurses and bosses to
visit Haiti. Both women felt the nurses were insensitive to their language
difficulties and ignorant about their Haitian upbringing and culture. They felt
that an attempt by their bosses to understand “where they come from” would go
a long way in repairing damaged relationships between colleagues. Cultural
sensitivity training could also foster a more supportive environment, providing a possible pathway for caregivers to lodge complaints about client-caregiver racism and abuse in attempts to get reassigned without fear of retribution. Such training should be just one element of a comprehensive cultural change within eldercare institutions. Minimizing the deeply stratified nursing hierarchy and instead actively soliciting the valuable advice of caregivers at the CNA and HHA levels would improve both informed compassionate care as well as provide these caregivers with a measure of pride and satisfaction.

To be sure, many of the perspectives and practices described in this study are contingent on evolving policy measures. For example, if spending cuts on programs, benefits, and services such as Social Security, Medicare and Medicaid are passed in Congress, perceptions of care and care practices may evolve. Additionally, proposed restrictive immigration proposals that plan to remove visa categories that allow adults to sponsor other adult family members would make the sponsorship process for caregiving purposes quite difficult. Given the dynamism of this topic, the perceived differences in benefit distribution across different U.S. states, and the importance in constantly evaluating care practice to continually make improvements, future research could explore how transnational immigrant caregivers who live in states other than Massachusetts
determine how to care for their aging relatives and clients. These stories of transnational families also lay the groundwork for future studies on the beneficiaries of these caregiving practices. How do care recipients in the countries of origin feel about these new forms of care? How do elderly clients feel towards their immigrant caregivers?

From sending a walker to an aging relative to drawing up plans to establish caregiving systems and programs in the countries of origin, these caregivers affect change with their transnational family dynamics. They provide a valuable perspective on the current state of care and how to better it for future generations.
## APPENDIX 1: SAMPLE

### A-1: Female Immigrants Working in Direct Care (n=40)

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Age</th>
<th>Length of Time in U.S. (years)</th>
<th>Role</th>
<th>Workplace</th>
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<td>Esther</td>
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<td>HHA</td>
<td>Licensed and Insured Home Care Agency</td>
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<td>Anita</td>
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<td>Haiti</td>
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<td>Haiti</td>
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<td>Licensed and Insured Home Care Agency</td>
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<tr>
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<td>Ghana</td>
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<td>James</td>
<td>Kenya</td>
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</table>
APPENDIX 2: INTERVIEW GUIDE

Interview Guide for Interviews with U.S.-based caregivers

Subject ID: ______________________

A. Demographic Information

a. Where were you born?

b. How old were you when you moved to the United States?

c. If you don’t mind me asking, how old are you now?

d. When you migrated, did any other family members come with you? If so, what relation?

e. Did you join any family members that were already here? If so, what relation?


g. Sex- Female Male

B. Life History

a. Can you tell me a little about your life growing up in (insert country)? What do you miss most?

b. Can you tell me a little about your parents?

1. Age?

2. Do they live in the house where you grew up? If not, why did they move?
c. How was your relationship with your parents growing up?

d. What is your relationship like with your parents now?

e. How do you maintain a relationship with your family members abroad?

f. What do you expect your parents and elderly relatives’ care needs will be in the future?

g. How will their needs be accommodated?

h. Who takes/took care of the needs of your grandparents? Why?

C. Making the Move – Migration to Boston and Finding Work

a. Why did you decide to migrate to the United States?

b. What made you decide to live in the Boston area?

c. What were your first impressions of the United States? Places? People? Family Relationships?

d. How did you come to work as a home care worker/nursing assistant?

D. Characteristics of Caregiving Work

a. Could you describe to me what is involved in a typical work day?

b. How would you describe the relationship you have with your patients/clients?

c. What would you describe as the most important task of your job?

d. What do you like most about your job?
e. What do you dislike most about your job?

f. What do you feel is the most difficult part of your job?

g. In your opinion, what makes a “good” caregiver?

h. Have you always worked as an (insert type of caregiver) or have you performed other jobs in either eldercare or other fields?

i. If so, how would you compare working in those jobs to the job you work in now?

E. Perspectives on the home health care/nursing home system in the U.S./Sending Country

a. What do you consider the strengths to be of how the U.S. cares for their elderly?

b. What do you consider the weaknesses to be of the U.S. eldercare system?

c. What do you consider the strengths to be of how (insert sending country) cares for elderly?

d. What do you consider the weaknesses to be of the eldercare system in (insert sending country)?

e. Are you familiar with any programs like the one you’re working in here, where you are from?

F. Perspectives on Aging in the U.S. versus abroad

a. What do you envision your life to look like in 10 years? 20 years?

b. Where would you like to spend your old age? Why?


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CURRICULUM VITAE: MEGAN ELIZABETH O’LEARY

Boston University
Department of Sociology
100 Cummington Mall,
Room 260
Boston, MA 02215

meoleary@bu.edu
339-927-4330
June 1985

EDUCATION

Ph.D., Boston University, Sociology

Dissertation: “Caring Here, Caring There: Boston-Based Black Immigrant Caregivers as Agents of the Globalization of Eldercare”

Qualifying Exams: International Migration, Globalization

Committee: Dr. Nazli Kibria (Chair); Dr. Julian Go; Dr. John Stone

B.A., Providence College, Sociology & Psychology (2007)

Summa Cum Laude; Alpha Kappa Delta Sociology Honor Society; Psi Chi Psychology Honor Society; National Society of Collegiate Scholars

TEACHING EXPERIENCE

Senior Teaching Fellow, Department of Sociology, Boston University

Lecturer, “Sociology of the Family” (Spring 2012)

Lecturer, “Urban Sociology” (Spring 2011 and Spring 2010)

Teaching Fellow, Department of Sociology, Boston University

Teaching Assistant, “Sociology of Popular Culture,” Professor Ashley Mears (Spring 2014)
Teaching Assistant, “Introduction to Community Sociology,” Professor Dan Monti (Spring 2008)

Teaching Assistant, “Principles in Sociology,” Itai Vardi (Fall 2007)

**Grader, Department of Sociology, Boston University**

“Sociology of Childhood and Youth,” Professor Nazli Kibria (Spring 2013)

“American Family,” Cara Bowman (Fall 2012)

“American Family,” Professor Nazli Kibria (Fall 2009)

“Developing Countries,” Professor Susan Eckstein (Fall 2008)

“Urban Sociology,” Professor Dan Monti (Fall 2007)

**RESEARCH EXPERIENCE**

**Research Assistant, Department of Sociology, Boston University**

Research Assistant to Professor Japonica Brown-Saracino (Fall 2011)

Research Assistant to Professor Nazli Kibria (Fall 2010)

Research Assistant to RULE Grant Proposal Team: Professor Nancy Ammerman, Professor Julian Go, Professor Ashley Mears, and Professor Sigrun Olafsdottir (Summer 2010)

Research Assistant to Professor Julian Go (Fall 2009)

**PUBLICATIONS**

AWARDS, GRANTS AND FELLOWSHIPS

Awards

Rose Laub Coser Award, Eastern Sociological Society (2013)
  Outstanding doctoral dissertation proposal in the area of family or
gender and society for “Caring Here, Caring There: Boston-Based
Black Immigrants as Agents of the Globalization of Eldercare”

Outstanding Sociology Major, Department of Sociology, Providence
College (2007)

Academic-Based Scholarship, Providence College (2003–2007)

Grants

Graduate Student Travel Grant, Morris Fund, Department of Sociology,
Boston University (Spring 2015; Summer 2014; Spring 2013)

Travel Fund Award, Lee Student Support Fund, Society for the Study of
Social Problems (SSSP), (Summer 2014)

Dissertation Research Support Grant for Transcription Assistance, Morris
Fund, Department of Sociology, Boston University (Spring 2014)

Graduate Student Travel Grant, Boston University Graduate Student
Organization (GSO), Boston University (Fall 2013)

Dissertation Research Support Grant for Participant Gifts, Morris Fund,
Department of Sociology, Boston University (Fall 2011–Spring 2012)

Collaborative Research Grant (with Professor Nazli Kibria), Morris Fund,
Department of Sociology, Boston University (2009, 2013)

Fellowships

2014–2015 Sociology Department Dissertation Writing Fellowship,
Department of Sociology, Boston University, (Spring 2015)
2014 Summer Research Fellowship, Graduate School of Arts and Sciences, Boston University, (Summer 2014)

Fellowship with Dr. Peter Berger, Institute on Culture, Religion and World Affairs (CURA), Boston University, (Fall 2008 – Spring 2009)

PROFESSIONAL ACTIVITIES

Departmental Service

Graduate Student Representative, Seminar Series Committee, Department of Sociology, Boston University (2013–2014)

Graduate Student Representative, Morris Fund Committee, Department of Sociology, Boston University (2012–2013)

Graduate Student Representative, Urban Sociology Faculty Search, Department of Sociology, Boston University (Spring 2010)

Program Coordinator, Society, Politics, & Culture Workshop Series, Department of Sociology, Boston University (Fall 2009)

Editor/Reviewer

Student Editorial Board Member, Political Power and Social Theory (2009–2010)

Mentorship

Graduate Student Mentor, Graduate Student Mentor Program, Department of Sociology, Boston University (2010, 2014)

Invited Panelist for New Student Orientation, Graduate Student Mentor Program, Department of Sociology, Boston University (2011)