Immigrant Home Health Workers Experiences: Qualitative Description Study

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Immigrant Home Health Workers Experiences: A Qualitative Description Study

A dissertation
by

Patricia Yu

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of the requirements for a degree of
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Dissertation Chair: Dr. Ruth McRoy

Abstract

Unmet long term care needs are increasingly filled by immigrant home health workers who are primarily female (88%), racial minorities (85%), and from developing countries including Mexico, Caribbean, Philippines, and Africa. The growing numbers of immigrant home health workers are a result of global factors including economic policies, colonial histories with developing countries, and immigration legislation. In addition to macro factors, personal motivations lead migrant home health workers to immigrate and find jobs in the U.S. Once in the U.S., little is known about migrant home health workers' caregiving experiences and work conditions. This study was designed to address this need and explored the personal experiences and viewpoints of the workers. Additionally information on migration histories and work setting was gathered to contextualize caregiving experiences. The study was guided conceptually by caregiving theory on the commodification and devaluation of "care" which can ultimately result in outsourcing care to immigrant women. Qualitative description methods were used to guide the research design, data collection, and analysis of twenty-three semi-structured interviews of female immigrant home health workers in Massachusetts. Interviews focused on three topics: caregiving experiences, reasons for migrating to the U.S., and work conditions. Findings will add to the knowledge base about immigrant home health

workers paying particular attention to how workers themselves describe their experience

which will in turn inform future policy and program initiatives on inclusion of a

multicultural workforce into the long term care system.

DEDICATION

I dedicate this study to my mother,

the smartest and most empowered immigrant woman I know.

being patient when I worked on vacations or opted to not attend weddings, dinners, or other important events. Your undying confidence in me and encouragement will never be forgotten.

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Chapter I. Introduction

Background

Within the last thirty years, the significant need for elder care services for the old and disabled has increased due to demographic shifts including declining fertility rates, increased life expectancy, and greater female workforce participation. It is predicted that the dramatic increase in old age dependency ratios will double in industrialized nations and triple in developing nations by 2050 (United Nations Programme on Aging, 2012). This may leave many countries with a severe need for more elder care services that many governments are not prepared to address.

Currently nine million older Americans need long term care and it is estimated that twelve million older adults will need daily assistance by the year 2020 (Medicare.gov, 2012). The overwhelming majority of long-term care is provided in non-institutional settings with seventy percent of disabled or frail elderly persons receiving care from family or friends (Medicare.gov, 2012). Many of these elderly have voiced a strong preference to receive services within the home, generating an "aging-in-place" consumer demand (Mollica, 2003).

Consequently, home health and personal care work will be one of the fastest growing occupations in the next ten years, with an expected seventy percent growth in jobs (approximately 1.8 million jobs), higher than average for other occupations (US Department of Labor, 2012). Despite such surprising growth in the supply of jobs, it is well documented that worker shortages will continue (Stone, 2004, US Senate Special Committee Aging 2009, PHI National, 2008). Overall data suggest that turnover rates vary widely from 40% to 100% annually (American Health Care Association, 2003). But

it can be concluded that elder care staffing needs will go unmet with a native born workforce.

Due to persistent worker shortages, wealthier nations have increasingly turned to poorer countries to help fill the gap in caring for the elderly (Browne & Braun, 2008a). The combination of high demand for home health workers and difficulty filling positions stateside has led to increased employment of newly arrived immigrants into home based care work. Increasingly, the direct care labor force is foreign born (23%) and primarily women (88.3%) (Polson, 2011). According to the most recent data available, the majority of immigrant elder care workers come from the Caribbean, Philippines, and Mexico, although the country of origin may vary in different regions of the United States (Martin, Lowell, Gozdziak, Bump, & Breeding, 2009; D. Redfoot & Houser, 2008b).

Despite the knowledge that elder care needs will be increasingly met through a largely immigrant workforce, research and policy have not focused on this population. Few quantitative or qualitative studies have examined paraprofessionals in home care settings. Even fewer have focused on immigrant workers themselves.

Statement of the Problem

Though elder care needs will be increasing in the next ten years, persistent high vacancy and turnover rates of home health workers are anticipated due to their relatively low status, negative public image, poor pay, difficult working conditions, and recruitment challenges (Menne, Ejaz, Noelker, & Jones, 2007). There are few advancement opportunities for home health aides and they are perceived as a low skilled and underpaid group. In 2010, median hourly earnings for home health aides were $9.70 (U.S. Department of Labor, 2012), with Massachusetts having a slightly higher than national

average at $12.13 an hour (PHI National, 2011). PHI National (2011) estimated a third of aides do not have health insurance. Approximately 45 percent of direct care workers live in households earning below 200 percent of the federal poverty level of income, making them eligible for many state and federal public assistance programs. Nearly half of direct care workers receive food stamps, Medicaid, housing, child care, or energy assistance. The landscape of paraprofessional work seems bleak and suggests that homecare workers, though gainfully employed, can also be viewed as a vulnerable population themselves.

Challenges within homecare work have deterred retention of native born workers but have become attractive opportunities for newly arrived immigrant women. The Bureau of Labor Statistics (2010) found that direct care workers were middle aged and female, more than half non-white, and about 23% were foreign born compared to just 15.5% of the U.S. labor force as a whole. Over half of foreign born direct care workers are naturalized citizens. Largely, foreign born direct care workers are racial minorities including 37% Black and 32.6% Hispanic primarily from the Caribbean and Mexico (Polson, 2011). Though U.S. born direct care workers usually have less than a high school diploma, immigrant direct care workers are more educated: 26.5 % have an associate's degree or higher, suggesting downward mobility of immigrant direct care workers.

Although the prevalence of immigrant homecare workers suggests a need to understand their contribution to elder care, remarkably there is little known about migrant home health aides and their experiences. Taking into consideration that homecare work is often undervalued and undercompensated and involves a variety of stressors on the job,

very little is known on how immigrant workers are adjusting to the job. Very little is known about their migration histories and possible trauma they may have faced prior to arriving in the U.S., as well as the effects of prolonged separation from their loved ones. More importantly questions arise about the ethical and human rights considerations of employing a caregiver from a developing country, displacing their care responsibilities back home in order to care for a disabled elder that is likely to be a different race and class. Also little is known about specific challenges they may be facing including discrimination, cultural or language barriers (Reinhard, Redfoot, & Cleary, 2009), and having less time for their own familial caregiving responsibilities.

Despite the barriers to care work, home health aides find the relational part of the work to be the most meaningful to them. (Bowers, Esmond, & Jacobson, 2000; Bowers, Esmond, & Jacobson, 2003; Chichin & Kantor, 1992; Erdmans, 1996). But there exists the tension for caregivers as they are paid for the instrumental part of the job, but the affectual portion of the work is continuously devalued and minimized by bureaucratic expectations of efficiency and productivity. (Neysmith,S. M. & Aronson, J., 1996). Although workers are encouraged to maintain professional distance, many home health aides continue to offer emotional support to their elderly clients. The relationship with the client serves as a stress buffer and increases job satisfaction but also blurs boundaries, which may lead to the worker doing unpaid work by spending time doing favors for the client. We know little about what the migrant home health worker experiences as they build a relationship with their client and the rewards and stressors that might simultaneously occur.

Often caregiving is seen as unpaid or poorly paid "woman's work." Migrant women working as caregivers are especially vulnerable to exploitation as domestic service is often paid under the table and local labor laws not enforced (Browne & Braun, 2008b). Fundamental to a feminist analysis of carework is the understanding that whether caregiving is paid or unpaid it impacts the personal and political boundaries of family, employment, and economic policy. Carework is often considered women's work, an assumption that it is innate or natural for women to provide caregiving so it is unnecessary to be compensated and is unremarkable (Neysmith,S. M. & Aronson, J., 1996). Extensive literature of women's work and caregiving alerts us to ideological and political processes through which care labor is devalued and emotional work eclipsed. Yet workers find the affective portion to be the most meaningful to them.

Taking into consideration the innumerable difficulties of low wage work, how the care worker experiences and understands constraining work environments is essential to investigating worker well-being and client quality care. Additionally the challenges that immigrant workers face such as discrimination, cultural misunderstandings, or language barriers impact the caregiving experience.

Purpose

The purpose of this study is to describe and assess the experiences of immigrant home health workers in the Massachusetts area. More specifically, the primary focus of the study is the caregiving relationship and the meanings that workers prescribe to them. A sub-focus of the study is the interpersonal or organizational contexts that encourage or deter caregiving relationships. Additionally, since little is known about this population, contextual information will be gathered on their immigration histories, as well as work

patterns on immigrant caregivers. Previous literature has primarily focused on acute care settings. Homecare is most often studied from the viewpoint of homecare organizations, leading to gaps in knowledge about the home health worker experience.

This study relies on caregiving theory to address the role that affective care plays in the caregiving process. Although home health work is not specific to gender, immigrant women vastly outnumber men in health care (United Nations, 2005). For this reason, the investigation will solely focus on female migrant home health workers. Qualitative description methods will be used to interview and analyze the data from (n=23) female migrant home health workers in the Massachusetts area. The study investigates the migratory patterns of female immigrant home health workers and their experiences once they are on the job.

Research Questions

This study focuses on the experience of immigrant home health workers as they develop relationships with their elderly clients. Contextual questions serve to give a more holistic account about the experience of being an immigrant caregiver as so few studies have examined this population.

- Primary Research Question: How do immigrant home health workers describe their caregiving relationships with clients?

   Subquestion: What are the interpersonal and organizational strengths and barriers to providing care?

   Subquestion: What are the differences in perceptions and experiences of Caribbean and African home health workers?

- Contextual Question: What are the migration experiences of immigrant home health workers?

- Contextual Question: What are the work patterns of immigrant home health workers?

Significance

Migration of Caregivers

Globally there are 232 million migrants, the largest number (46 million) residing in the United States alone (United Nations, 2013). Remarkably different than previous migration trends, today's migrants are more likely to be female and older (United Nations, 2013). Research has found that older women are most often employed in traditional female caregiving positions such as domestic work, child care, nursing, and teaching (United Nations, 2005). The demand for care labor has increased the global movement of female workers overall. Current literature points to several macro factors fueling the movement of women from developing countries to places like the U.S., Canada, and Europe. Migration factors including push factors out of the source country and certain pull factors in the receiving country have been discussed in the literature.

Factors impacting caregiver migration

The increase of foreign care workers is primarily being fueled by the rapid demographic changes in developed countries, including the combination of quickly aging population and the slow growth of native born workers that has increased the demand for paraprofessionals in long term care (Browne & Braun, 2008a; Browne & Braun, 2008b; D. Redfoot & Houser, 2008b; Reinhard et al., 2009). U.S. Department of Labor (2012) projects an astounding 70% growth in jobs, growing by 1.8 million jobs within the next ten years. However the numbers of workers to fill entry level jobs in direct care are only projected to increase by 3.2% in the next seven years (PHI National, 2008). The alarming

shortage of direct long term care workers illustrates the dramatic pull of foreign

careworkers to fill these positions.

The central issue related to home health work is the dual labor market centered on

"women's work" attracting foreign women from poor developing countries into elder

care in the U.S. (Browne & Braun, 2008b; Reinhard et al., 2009; United Nations, 2005).

The concept of a 'global care chain' first used by Hochschild (2000), describes the

transnational transfers of care provision supplying women with their own care labor

needs by consuming other women's paid and unpaid care labor (Yeates, 2005). While

most literature on global care chains focuses on the migration of domestic workers, in

particular nannies, home health care, a growing service sector, faces many of the same

issues. The internationalization of these care labor markets has racial, gender, and class

implications. Outsourcing care labor is ultimately based on social divisions drawing

migrant women from ethnic minority groups to provide care for the elderly (Yeates,

2005). Often female careworkers are employed in low paying, insecure jobs ultimately

leading to higher unemployment rates than men, which in turn fosters feminization of

poverty among women who immigrate for employment (Browne & Braun, 2008a; D.

Redfoot & Houser, 2008b; United Nations, 2005).

Policies impacting caregiver migration

Consensus amongst researchers from different disciplines emphasize the role of

global policies funneling migrant women into care occupations (AARP Global Aging

Program, 2005; Browne & Braun, 2008a; D. Redfoot & Houser, 2008b; Tung, 2000;

Yeates, 2005) . Though previous literature tended to discuss policies that increase

migration amongst highly skilled immigrant workers such as nurses or doctors in long

term care, there is less known about paraprofessionals (AARP Global Aging Program, 2005; D. Redfoot & Houser, 2008b; D. L. Redfoot, 2005). However, these theories also provide a macro perspective to view the movement of paraprofessional workers globally.

Kingma (2007) describes the combination of economic policies, bilateral and trade agreements, and recent legislation that facilitates extensive nursing migration (Brush, 2007; ICN, 2005; Salmon, Yan, Hewitt, & Guisinger, 2007; Simeons, Villeneuve, & Hurst, 2005). Past colonial histories of developed countries play a significant role in migration patterns, as virtually all foreign long term care workers come from former colonies in Africa and Asia, in particular India (Nursing and Midwifery Council, 2007; Salmon et al., 2007). The Philippines, a former U.S. colony (years 1898-1946), continues to be the largest supplier of nurses and nurse aides, but significant numbers also come from Jamaica, Mexico, Haiti, and Puerto Rico (AARP Global Aging Program, 2005; Arends-Kuenning & McNamara, 2004; D. Redfoot & Houser, 2008b). Browne and Braun (2008) describe the extent the Philippine government encourages the exportation of long term care workers through its policies, regulations, contracts, and training programs. Such policies have been argued to serve the interests of the source country government but the workers' families themselves benefit economically (Brush, 2007).

In response to nursing shortages, a provision of the U.S. Immigration Reform Act of 2006 removed the limit of special visas for foreign nurses to allow entry for all qualified nurses (Dugger, 2006). In other cases, mutual trade agreements have encouraged nursing migration regionally (i.e. Protocol II of the Caribbean Community and Common Market, the North American Free Trade Agreement, Trans-Tasman

Agreement, Nursing Directives of the European Union, Within the Asia-Pacific

Economic Cooperation) (Kingma, 2007). Between 1989 and 2009, about 11,000 foreign

trained nurses entered the U.S., using temporary work visas (H-1A and H-1C) (Martin et

al., 2009).

In contrast, direct care workers enter the country typically through the auspices of

reuniting with family, as refugees, green-card lottery, or illegally (Leutz, 2011). The most

comprehensive study to date of migrant care workers in the U.S. was by Georgetown

University which found that unlike higher skilled health professionals, direct care

workers tend to find jobs through word of mouth from their communities and acquire

modest amounts of training in the United States (Martin et al., 2009). Overall 24 percent

of the direct care workforce are immigrants, with an estimated 79 percent of immigrant

direct care workers being legal residents, bringing their numbers to around 565,000

documented workers in the U.S. (Martin et al., 2009). Immigrant direct care workers tend

to live in twenty-four metropolitan areas in the U.S. with high proportions in New York,

Los Angeles, and San Francisco (Leutz, 2011). According to Martin at al. (2009), two-

thirds of all immigrant direct care workers come from the Caribbean, Asia, or Mexico-

Central America and three countries in particular account for a third of all the workers:

Mexico at 15 percent, Philippines at 9.7 percent, and Jamaica at 9 percent. In addition to

the macro factors facilitating movement of healthcare workers (Kingma, 2007), the

decision to immigrate to a foreign land is largely personal, one driven by economic

motives and self-preservation.

Personal reasons to migrate

Personal factors play a major role in the decision making process to migrate. No one theory has captured all the forces that influence an individual's decision to migrate. However several studies have provided a helpful framework to assess the overall impact of various factors on migration trends for nurses and nurses' aides. Kingma (2007) suggests that financial incentives are a major "pull" factor in the migration decision making process. "Pull" factors reflect actions and omissions of the recipient country to create demand or encourage migrants to leave home (Dovlo, 2007), such as recruitment practices or immigration policies. Though the length of stay of immigrant workers can be temporary or short-term, "stay" factors in the destination countries make it difficult for them to return. Stay factors may include reluctance to disrupt family life or children's schooling, lack of employment opportunities at home, and higher standards of living in the recipient country (Dovlo, 2007; Padarth, Chamberlain, Ntuli, Rowson, & Loewenson, 2003).

In addition to the macro considerations such as a country's political situation, existing diaspora (people settled outside ancestral land) or colonial history, other personal factors play a role in migrating. A person might consider their age, poverty, employment or educational opportunities, during their decision making to migrate (Padarath et al., 2003). For African and Caribbean nurses, "push" factors in the source country included poor compensation, poor working conditions, lack of professional development, lack of opportunities, occupational risk, distrust in management, and welfare and security during employment and retirement concerns as reasons to migrate (Dovlo, 2007; Kingma, 2007; WHO, 2004) Previous studies also illustrate personal reasons as to why medical

professionals may hesitate to leave due to "stick" factors in the source country mainly related to family and community bonds or psycho social links, and the costs to migrate (Padarth et al, 2003; Dovlo, 2007).

Consequences of Migration

The migration of large numbers of nurses and doctors has led to devastating consequences for vulnerable source countries within Saharan Africa and the Caribbean (Brush & Sochalski, 2007). An exodus of African nurses to the U.S. to work in long term care settings is of particular concern as Africa bears not only 25% of the world's diseases but only has 1.3% of the world's health professionals (Gbary, 2005; WHO, 2004). The Caribbean is in the midst of a nursing shortage, with an average vacancy rate of 42 percent. Attempts are being made to slow down or at least manage the migration of nurses. In 2001, the ICN, a global nursing association established policy guidelines to govern nursing mobility and the International Labor Organization (ILO) have also set up legal standards to guide national policy for training on codes of practice and ethical international recruitment of nurses (Kingma, 2007). Though 37 countries have adopted these conventions, the major destination countries have elected not to do so, including the U.S.

Despite the potential for brain drain of international migration, the notion of "brain gain" is now more commonly adhered to where the benefits of migration in terms of reverse flow of innovations, ideas, remittances, and investment outweigh the costs (Datta et al., 2006). Some studies suggest a more nuanced view of migration being a circular flow of workers where workers emigrate and later return to their home country (Kingma, 2007; Padarth et al., 2003). With the reverse flow of workers comes enhanced

skills and knowledge that working abroad might bring. One of the primary gains for source countries are the substantial remittances sent back by workers abroad, supporting their families and economies in home countries (Datta et al., 2006).

Remittances globally make up a large portion of the economy in developing countries. A World Bank (2006) study of 71 developing countries found that remittances were able to reduce the level of poverty overall. In 2005, remittances totaling $167 billion (U.S. Dollars) were sent to the developing world, right behind Foreign Direct Investment (FDI) and ahead of Official Development Assistance (ODA) (World Bank, 2006). The largest remittance source is the USA, sending US $21.7 billion to India as the top recipient country, followed by China and Mexico (Brown & Cullis, 2006; Ratha, 2003). From the perspective of development of the Global South, migration and remittances do not contribute to development and create dependent relationships between migrants and non-migrants, leading to economic instability in countries with low GDP while eroding their human capital. Alternatively, the Global North links migration to household survival and loosens the burdens on poor households worldwide. Perhaps workers themselves may paint a more complex picture in which source countries and families may gain financially by them working abroad but other more interpersonal losses that are harder to measure are the real consequences of migration of female caregivers abroad.

Migration of caregivers creates gaps in the home country's ability to care for their own elders and children (Chang, 2000). Careworkers with transnational families have intense feelings about arranging care for their children or parents in need of long term care (Bauer & Österle, 2013). Feelings of guilt and sorrow for their absence are frequently justified by improving living standards and better education for their children.

Compensating for the inability to provide love and care with material goods is common amongst transnational families (Parrenas & Rhacel, 2001). Hochschild's (2002) essay titled, "Love and Gold," describes the coerced love by caregivers from the developing world partly fostered by the intense loneliness and longing for their own children and families. Hochschild provides several examples of mothers suffering from their prolonged separation and easing this guilt by sublimating their love with affection and love to the American children they are raising.

Essentially love and care are being imported from poor countries to rich ones illustrating a global transfer of caregiving (Ehrenreich & Hochschild, 2004; Yeates, 2005). Contrasting the more commonly known brain drain, "care drain" has an impact on women's relationships and communities, where women forego their care responsibilities in their own poor countries to care for the young and old in rich countries. Hochschild's (2000) global care chain connects the personal and transnational dynamics of a woman in a rich country entering paid employment and unable to fill her domestic duties, purchases the care labor from a migrant woman, where the caregiver is now drawing on the care labor of her extended family or community to provide care for her dependents (Yeates, 2005). This outsourcing of care labor highlights the social divisions and inequalities of wealth, class, and race between source and destination countries (Yeates, 2005).

The migration of women into caregiving jobs fueled by globalization of care labor brings about consequences for source countries and their workers. In order to provide a better standard of living and to help with their children's education, many women are willing to make sacrifices. However the remittances sent back home must be weighed against the loss of leaving their care responsibilities behind, causing great anguish to the

migrant mother working abroad and their children left behind. Many of global care work theories have focused on nannies and domestic workers and though many of the issues are likely to be related to paraprofessionals in long term care, previous studies have not examined them. Within this study, immigrant home health workers will be asked about their migration histories and kinship networks to verify if these theories also hold true for direct care workers.

Definition of Terms

The following definitions are to provide the reader with initial understanding of the multifaceted nature of home health work. Definitions were drawn from National Service Workforce Resource Center and were commonly used terms by respondents and homecare agency directors in this study.

Home health worker may also be called paraprofessional, direct care worker, certified nursing assistant, caregivers, aides, or personal care attendants (Shierholz, 2013). There is not a single unifying occupational title and titles are often employer generated and vary widely both across and within geographic regions (National Direct Service Workforce Resource Center Research, Nov 2008). Titles are used interchangeably in this study to reflect literature from differing disciplines such as nursing (nurse aides), sociology (caregivers), or social work (home health workers).

Job duties of home health workers are to provide hands-on care to the frail elderly. Services include providing *personal care* such as bathing, dressing or toileting. Workers also provide *instrumental care* including grocery shopping, housekeeping, and managing money. Contribution of this study is on the *emotional care* that workers provide to elderly clients including socialization, listening, empathy and encouragement.

Home care settings are community based settings including a variety of residency settings which may include living alone, with family or friends, senior housing, or independent living facilities (Martin et al., 2009). Home care settings are more private in nature and the work setting offers more autonomy, less supervision, and the ability of the worker to care for one client at a time (Lindahl, Lidén, & Lindblad, 2011).

Home care agency refers to the for profit agencies that employed home health workers to provide hands on care of the elderly. Agencies employed the home health worker on an hourly basis but did not guarantee full-time work. Though respondents were recruited through one agency, generally respondents worked for multiple agencies at a variety of settings including residential facilities or hospitals and their answers reflected an amalgamation of their experiences rather than a single work setting or agency.

Documented worker refers to the immigration status of the respondents. All respondents were legal residents, who are entitled to live and work in the U.S. as permanent residents or citizens, work visas or student visas. It was a deliberate decision to exclude undocumented workers as different factors and experiences are likely to impact their experience as an immigrant worker.

Summary

Though immigrants make up 23% of the direct care workforce, research and policymakers have largely ignored their contribution (Polson, 2011). Research on migrant direct care workers is still in its infancy and tends to focus on migrants as a single group or focuses on one nationality (Doyle, M., Timonen, V., 2009) This study compared and contrasted the experiences of Caribbean and African home health workers with special

attention to their caregiving experience caring for the elderly. The study investigated the personal and organizational contexts that help facilitate relationship building or become a challenge to creating connections. Additionally, contextual information on their immigration histories and kinship patterns was collected. Lastly, the work patterns of immigrant workers will be studied to give an overall understanding of their work life.

Chapter II. Conceptual Model

Introduction

"Caring" is fundamentally the central core of providing quality care within elder services. Efficient personal care and home making services are important elements of caring for the elderly, but the real benchmark is the caring relationship between worker and client. The frail and disabled elderly are a vulnerable population that relies on compassion and assistance from others. For many isolated elderly clients, the worker serves as not only a connection to the outside world but adds to their overall well-being and enhances their quality of life. From the worker's perspective, caring for the client is the most rewarding part of the job and adds to their over-all job satisfaction (Bowers et al., 2000; Bowers et al., 2003; Chichin & Kantor, 1992; Erdmans, 1996).

According to care work literature, high quality care involves not only efficient instrumental care, but also incorporates affective care (Abel & Nelson, 1990; Diamond, 1992; Foner, 1994; James, 1992a). Qualitative studies have described affective relations as essential to good quality care and nurses' aides have well developed concepts about the care they want to deliver (Anderson, Wendler, & Congdon, 1998; Berdes & Eckert, 2007; Deutschman, 2001; Stone, 2000). Stone (2000) found that aides described the gold standard of care by likening it to how they would care for their own families. Paid caregivers used the word "love" to distinguish "good care" from "good technical care" (Stone, 2000).

Within this chapter, the concept of paid care is explored within eldercare settings and its impact on immigrant homecare workers is discussed. Care, when provided by paid employees, is transferred from family to workers and becomes "commodified."

Undeniably positive caregiving experiences are valued by both the recipient and the caregiver emotionally. However, homecare agencies often give confusing suggestions to their workers to "be professional and efficient" in their work yet "behave like family". Emotional labor theory suggests that institutional expectations of workers to display certain emotional responses is indeed skilled work and requires effort on part of the worker. The devaluation of emotional labor in eldercare settings suggests that it is not recognized as part of the competencies that leads to fair compensation or promotions in the workplace. The conceptual model illustrates three aspects of care in the provision of homecare services: a) care as a commodity b) care is devalued and c) care is outsourced to immigrants. Additionally I will examine previous literature on a) homecare relationships with elderly clients and b) immigrant home health workers. Few studies have evaluated immigrant elder care workers' perceptions of "care" in the context of the workplace. In this study, carework theory is used as a guide in understanding their perceptions.

<div align="center">**Care is a "commodity"**</div>

The redistribution of unpaid "family care" to paid homecare workers, transfers "care" into a commodity. Changes within society and the increase in two wage earners are shifting elder care responsibilities from family members to those of paid workers, yet there is great difficulty reconciling the idea of paid "care" for ones' own family. The increased outsourcing of care labor is introducing the idea of commodification of care into domestic spheres where the paid worker is now responsible for the emotional component of "caring" for the elderly client (Bauer & Österle, 2013). The emotional demands of direct care workers in private households are invisible compared to the

visible tasks of providing personal care or conducting household tasks. However eldercare very much involves exhibiting emotions and feelings involved in giving care and taking care of a person in need. There are organizational expectations of exhibiting feelings of caring for the purposes of institutional goals as illustrated by emotional labor theory.

Emotional Labor Theory

Emotional labor theory emphasizes the role of homecare agencies and nursing homes to commodify "care" when workers are expected to portray emotions aligned with providing family-like care. "Commodifying" family-like care within health care settings is a deliberate effort to counter depersonalized mainstream health services and provide an alternative to family care. Imagery of "family" elicits ideas of warmth and individualized care which transfers a family model of care into the workplace (James, 1992b). Caring-like-family, is often an unstated assumption within eldercare organizations, but is very much part of the organizational expectations of direct care workers.

The process in which organizations transfer their emotional expectations onto the worker is described by emotional labor theory. First coined by sociologist Arlie Hochschild (1983), emotional labor theory refers to the alienating process of using one's own emotions for the purposes of work. Hochschild (1983) first defined emotional labor as inducing or suppressing feelings in order to sustain the outward countenance that produces the proper state of mind in others. Over the decades, emotional labor has been written about in several disciplines and understanding of the concept has evolved. Using the most recent definition in the nursing literature, emotional labor is defined as a process through which nurses or (nurses' aides) adopt a work persona to express their

autonomous deeply or superficially felt emotions during patient encounters (Huynh, Alderson, & Thompson, 2008).

Within her book, 'The Managed Heart' Hochschild (1983) first identified displays of emotional labor as a challenge for workers and she acknowledged the strain it placed on workers to exhibit emotions for the purposes of service or selling a product. Hochschild studied flight attendants and the expectations of airlines to commodify the appearance of friendly, competent, or sexy to airline passengers. One of the most essential parts of the job was to disguise fatigue and irritation towards customers. Essentially emotional displays were used to diminish any negative associations customers might have about flying in cramped quarters with strangers given the delays and inconveniences of traveling. Though having a desired emotional display is part of the organizational expectations, essentially workplaces perceived emotional work to be a deskilled form of labor, which was rarely compensated or recognized (Hochschild, 1983).

Hochschild (1983) also discussed the difference between superficial or deeply felt emotions in terms of "surface acting" and "deep acting." Surface acting involved workers displaying the desired emotional response such as a friendly smile to customers without genuine feelings of connection to them. Deep acting involved workers wholly identifying with their job, such as a teacher that genuinely liked young students. Essentially an important part of institutional management was to control worker's private sphere of feeling such as warmth and compassion, which was used as an instrument for service work. Though emotional labor is performed by both genders, women in particular, lacking resources, may take on more emotional work by being nice or deferential to gain more security in the workplace. Hochschild (1983) illuminated the previously unnamed

aspects of emotional expectations placed on workers and how organizations commodified feelings for the purposes of institutional goals but simultaneously devalued emotions as a skilled part of the work.

One of the major critiques of Hochschild's theory at the time was the lack of emphasis on the "individual agency" of workers and over emphasis on institutional control of workers. "Individual agency" refers to a person's ability to act independently and make ones own choice. More current scholarship (Bolton, 2005; Huynh et al., 2008; Mann, 2005; Smith & Lorentzon, 2005) has amended Hochschild's original theory (1983) to take into account that regardless of workplace expectations, individual workers ultimately choose to perform the expected emotional display or behave according to their own personalities and preferences.

Emotional Labor Concept

Recently, the most extensive exploration of the concept of emotional labor is by Huynh, Alderson & Thompson (2008), who conducted a detailed meta-analysis of emotional labor scholarship from the last twenty years through an interdisciplinary lens in nursing, medicine, management and psychology and re-purposed the existing theory for the nursing field. The term 'emotional labor' was used interchangeably with 'emotional work' (Dollard, Skinner, Tuckey, & Bailey, 2007; Hunter, 2001; Zapf, 2002) and other related terms that can be found in nursing literature as 'being there,' 'compassionate,' 'caring,' 'emotional intelligence,' and 'empathy' (Brilowski & Wendler, 2005; Larson & Yao, 2005; McQueen, 2004; Reeves, 2005).

The "emotional labor" concept is a useful transdisciplinary concept (Huynh et al., 2008). Across disciplines, emotional labor was either described as autonomous or

spontaneous emotional expression (Diefendorff, Croyle, & Gosserand, 2005; Shuler, 2001; Zapf, 2002). In the literature workers presented their work persona through either deep acts (deeply felt emotions) (Boyle. M., 2005; Kramer & Hess, 2002; Mann, 2005) or surface acts (superficially felt emotions) (Boyle. M., 2005).

Over the course of thirty years of emotional labor scholarship, one of the major additions to Hochschild's original theory was to address the critique of lack of focus on individual agency (person's ability to act independently).   Researchers have focused on workers' choices in their response to institutional commodification of human feeling. For example several nursing studies found that nurses exercised their "agency" and made an active choice to express care towards patients superficially to be polite or they may genuinely try to connect with them and show compassion (Bolton, 2005; Mann & Cowburn, 2005; Smith & Lorentzon, 2005). Huynh et al. (2008) describes surface acting of nurses when they synchronize their emotions to that of the patient's, without feeling them, yet laboring to establish an authentic and meaningful encounter with the patient. In particular, nursing literature highlights that emotional engagement with patients (Allan & Barber, 2005) led to nurses' feeling a sense of personal and professional accomplishment, an important component of job satisfaction (Mann, 2005; McQueen, 2004).

Hyunh et. al. (2008) created a middle range theory of emotional labor (See Figure 1) after review of several existent models in medicine, psychology, and management specifically for the field of nursing. There is gap in literature examining the emotional labor of direct care workers. For the purposes of this project, Hyunh et. al's. (2008) model will serve as the conceptual framework for this study.

Within Figure 1, the process of nurses' emotional labor is detailed; beginning with three antecedents, the intersection of the organization, nurse, and job factors preceded emotional labor.

Antecedents to emotional labor:

1. Organization (social norms)

2. Nurse (interpersonal skills, years worked as a nurse)

3. Job Factors (frequency of contact, work routines)

The first antecedent to the emotional labor process begins with organizations providing workers with scripted emotional interactions and sometimes social norms (Grandey, Kern, & Frone, 2007; Kramer & Hess, 2002; Ogbonna & Harris, 2004). Hyunh et. al. (2008) observed that across four disciplines, first social interactions with either co-worker/supervisors or family preceded emotional labor (Bono & Vey, 2005; Boyle. M., 2005).

Secondly workers' characteristics played a large part in displays of emotional labor. For instance workers are more likely to perform emotional labor the more experienced they were (MacKintosh, 2007; Zammuner & Galli, 2005). Psychologists argue emotional labor is performed when workers have interpersonal skills and health care researchers have shown that that professional job identification as a nurse or doctor is the key determinant of emotional labor (Froggett & Richards, 2002; Henderson, 2001; Larson & Yao, 2005; McCreight, 2005). Performance of emotional labor was based on social norms for nurses but strongly conditioned by personal variables (age, emotional adaptability) and the organizational culture to promote emotional interaction (McCreight, 2005; Schaubroeck & Jones, 2000).

Lastly, management studies on diverse service oriented occupations (sales, management, clerical, education, healthcare) found that job characteristics were key determinants leading to emotional labor experiences (Bolton, 2005; Gosserand & Diefendorff, 2005). Job characteristics included frequent interpersonal interactions or emotional demands of the workers, if the work routine allowed for connections between workers and clients, and the amount of work complexity all attributed to workers displaying emotional labor at their jobs.

Figure 1: Emotional Labor Theory Model

Antecedents

Organization

Job

Social norms (rules)
Social support

- Autonomy
- Degree of emotional demand
- Frequency of interactions
- Task routines
- Work complexity

Nurse

- Role identification
- Professional commitment
- Work experiences
Interpersonal skills

Attributes

Autonomous response

Persona

Surface act   Deep act

Consequences

Organization

Nurse

- "Cheerful environment"
- Productivity

a. *Positive aspects*
- Sense of personal and professional accomplishment
- Increased sense of connection between nurse-patient
- Job satisfaction
 b. *Negative aspects*
- Job-related stress
- Emotional strain
- Feelings of estrangement from self
- Burnout
- Depersonalization

(Huynh et al., 2008)

Within Figure 1, the interaction of the organization, nurses, and job factors act in a bi-directional fashion with the emotional labor process. For instance if the workplace has an organizational culture that expects emotional labor and the nurse is already strongly sociable, and his/her duties require frequent contact with patients, it is likely the

nurse will perform according to her health care organization's culture. Additionally professionals in healthcare also respond as "caring" individuals because it is part of the professional identity of nurses. Nurses either show care superficially or perform deep acts of connection with patients because it is part of the work persona as a healthcare professional (MacKintosh, 2007; Sharpe, 2005). In general, nurses want to genuinely care for patients as they feel it is part of the professional role and the work persona is an integral part of them (Lopez, 2006a). Work persona is described as the other (Bolton, 2005) or ideal nurse (Mazhindu, 2003) and constitutes genuine caring (Bolton, 2005; McCreight, 2005).

Figure 1 details the outcome of emotional labor of nurses. The health care setting benefits by having a cheerful or productive healthcare environment. Nurses experience both positive and negative outcomes from performing emotional labor. Nurses might gain a greater sense of job satisfaction with increased patient-nurse interaction. Nurses may have a greater sense of accomplishment professionally and perhaps personally by being helpful and kind. Consequences of emotional labor may also lead nurses to feel burnout and depersonalize their nursing persona from their genuine selves. Though emotional labor is expected by healthcare settings, the greater emotional responsibility leads to job stress at meeting increased demands.

Few studies have been devoted to nurses' aides and their performance of emotional labor within eldercare, Hyunh et al.'s (2008) middle range emotional labor theory on nurses serves as a useful framework to understand the process of emotional labor on part of homecare workers. For this study this conceptual framework will serve as a guide when viewing the interaction of homecare setting, direct care worker's

characteristics, and job factors which influence workers decision to care for their clients either superficially or deeply. Hochschild's emotional labor theory describes the process of commodification of feelings from a personal experience to the commodity of the workplace. For elder care settings, "care" expressed between the direct care worker and client moves beyond the interpersonal into a commodity that becomes a useful tool in service of eldercare organization's goals. Though eldercare organizations place importance in the presentation of family-like care from direct care workers, "care" is devalued and becomes an unrecognized and uncompensated part of the work.

"Carework" is Often Devalued

The commodification of care within eldercare settings transmutes a personal interaction between homecare worker and client into the public sphere of work. Though elder care organizations have cultural expectations of emotional labor of their workers, there is devaluation of the emotional part of the job as unskilled. The primary reason for the devaluation of caregiving is that it is stereotyped to be the responsibility of women. Carework, whether paid or unpaid, is often referred to women's work, "activities of nurturing, comforting, encouraging, facilitating interactions closely associated with women's natural or feminine proclivities" (Daniels, 1987). There is an underlying assumption that such activity is not seen as learned or skilled but rather an innate female need to nurture so therefore does not need to be rewarded equally to male dominated professions. Caregiving professions, not surprisingly dominated by a female workforce include teaching, nursing, eldercare, social work, housekeeping, and childcare. The continued devaluation and resistance to recognizing interpersonal skills of women as legitimate work indicates a pervasive gender stratification (Daniels, 1987).

In direct care work, gendered work values and gendered identities play a significant role in workers decisions to become and adapt to the role of caregivers (Morgan, 2005). The predominantly female workforce and the gender expectations play a significant part of workers' perceptions of the job. Morgan (2005) explores the reasons women become or remain as direct care workers knowing the low job quality and end up feeling the job is "good enough." Her exploration found at the heart of the direct care worker is a "mother's wit," a tactile knowledge on caring for others (Diamond, 1992). The gendered imagery of taking care of others ultimately reinforces women's career trajectory within elder care. Work values on caring are derived from past experiences and cultural expectations which undergird individuals' evaluation of their job quality and the meanings they attach to their jobs (Kalleberg, 1977).

Specifically Morgan (2005) found gender socialization, cultural, and religious context and past caregiving experiences shaped these women into good direct care workers and previous experiences of subordination and devaluation made them good low wage workers. A desire to care and help people draws women into caregiving jobs as it fulfills expectations of femininity and the traditional role of women despite complaints of low wages and poor working conditions. The intrinsic rewards of carework seem to outweigh the effects of low job quality for this group. In essence the devaluation of care work through low wages and lack of recognition is tolerated because of the women's desired gendered identities as caregivers (Morgan, 2005).

Elder care organizations often use these gendered notions of "care" and place great emphasis on direct care workers displaying emotions that coincide with feminine aspects of caregiving. The commodification of "family like care" within the hospice

setting are coined as "spending time," "involvement," "listening," "being there," "family care" (James, 1992a). Quality care not only involved instrumental care but adequate social and psychological care, and a growing emphasis on individualized care. However the "invisibility" of emotional labor is striking in elder care organizations as its associations with family can make it an ambivalent work skill. Ironically the ideology of family care attractive in hospice settings, also communicates the low status and lack of transferability of skills. Physical care associated with daily living skills can easily be observed and thus served as justification and explanation for paid work. Within organizations, physical work helped explain variations in status and division of labor and differences in salary between nursing staff, nurses' aides, and housekeepers. Because care is often seen as invisible yet valuable to an organization, staff nurses wouldn't complain that a patient wanted too much care but they could legitimately complain about overload of physical tasks.

Stacey (2005) found that homecare workers felt constrained to do a good job or experience work as meaningful because of the overwork and added responsibilities that becoming "one of the family" entails. Being part of the family often masks the inequality and exploitation of the carework arrangement such as taking on extra uncompensated work and at times providing financial assistance to isolated elderly clients. Emotional strain from overinvesting into relationships with clients led to alienation and burnout (Stacey, 2005). Nurses' aides are liable to suffer persistent grief when patients die hindering future attachments (Moss, Moss, & Black, 2003; Sumaya-Smith, 1995). A lack of reciprocity from clients hindered the development of a caring relationship or difficulties forming a relationship (Campbell, 2003; Stacey, 2005). With increased cross

cultural relationships between worker and client, there are bound to be cultural differences that come up (D. Redfoot & Houser, 2008a).

Additionally, carework literature points to substantial organizational barriers to providing affective care and role conflict illustrates the organizational barriers that inhibit attachments and disincentives care, where workers are made to feel affective care is at odds with bureaucratic expectations of productivity, efficiency, and professional detachment (Aronson, J. & Neysmith, S. M., 1996; Eliasson, 1990; Huller & McMillan, 2000). The dominant discourse on quality long term care emphasizes instrumental, practical aspects of care and Eliasson (1990) notes the trend toward the "conveyor belt" principle of organizing home care workers jobs much like the industrial image of greater speed and efficiency. The minimizing or obscuring of affective and relational dimensions of homecare work is due to the persistent devaluation of the affective portion of nursing and other occupations in which women do the care work (Aronson, J. & Neysmith, S. M., 1996; Diamond, 1992; James, 1992a). Lopez (2006) found that nursing homes with the most coercive forms of emotional labor expectations from direct care workers overly emphasized professionalism as a means to detach emotionally from clients and solely concentrate on the physical acts of caregiving. Empirical studies stressed that healthcare environments have unspoken rules to limit emotional displays with patients (Mann, 2005; Wear, 2006).

In the interpersonal context, there are several barriers to developing affective care for the client. The devaluation of emotional labor by elder care organizations added to workers' confusion about emotional displays in the workplace. Bailey et. al. (2014) found that nurses' aides displayed strategic balance between emotional engagement and

detachment due to the unpredictable and challenging behaviors of dementia patients. For instance lack of engagement with clients might be less about disinterest but perhaps reflect the conflicting rules workers faced in work environments to behave simultaneously professional and care like family (Bailey, Scales, Lloyd, Schneider, & Jones, 2014). Several nursing studies have positioned engagement and detachment as opposite stances in the provision of carework (Henderson, 2001; Kahn, 1990; Kralick, Koch, & Wotton, 1997). Some argue that individuals detach at the expense of engagement, usually due to stress and burnout, or disinterest or an uncaring attitude to engage (Astrom, Nilsson, Norberg, & Winblad, 1990; Carmack, 1997; Morse, 1991; Omdahl & O'Donnell, 1999). However Bailey et al. (2014) adds to the conversation by presenting detachment as an active emotional choice for workers to put aside certain feelings in the interests of completing one's job. Lack of engagement by direct careworkers could actually reflect conflicting organizational rules about socialization with patients.

Caregiving literature suggests that care within eldercare settings is simultaneously expected from direct careworkers and devalued as a skilled part of the work. Much of this devaluation is based on the perception that caregiving is the responsibility of women. Caregiving is highly associated with gendered expectations of women and despite significant challenges to the work, caregivers feel that their work fulfills a higher calling. Challenges exist within the organization and interpersonally to provide care, yet careworkers persist in providing a "gold standard" of care because of their own moral standards. The devaluation of carework creates enormous challenges for elder care workers as they are expected to simultaneously detach emotionally and provide a family-

like-care experience for their clients. This confusion can result in job stress and worker

burnout, and what Hochschild referred to as an alienation of the emotional self from their

work. An additional dimension worth exploring is the growing trend of outsourcing care

to immigrant women reflecting a transfer of care from developing world to wealthier

countries.

Carework is Outsourced

In many respects, the commodification and devaluation of carework has resulted

in educated women in industrialized countries entering the job market and outsourcing

their family care responsibilities to immigrant women. Eldercare increasingly reflects the

"feminized" and "foreignized" outsourcing of care labor (Bauer & Österle, 2013).

Currently, the direct care labor force is foreign born (23%) and primarily women (88.3%)

(Polson, 2011), and these numbers are only expected to increase with shortages of

American born workers willing to take on these jobs (PHI National, 2008). Women from

developing countries are finding themselves taking on and staying in elder care positions,

partially due to the cultural and gendered expectations of them.

For this reason, migrants today are more likely to be women and who are middle

aged or older, reflecting a demographic of caregivers that are leaving behind their own

caregiving responsibilities enticed by better pay and working conditions abroad (Brush,

Sochalski, & Berger, 2004). From a macro perspective, "care" in this context is being

transferred from developing countries to that of wealthier countries (Bauer & Österle,

2013). In essence wealthier countries have the advantage of having an abundance of the

emotional resources to care for the young, old, and sick, which leaves many developing

countries with a gaping hole in care, also known as "care drain" (Ehrenreich & Hochschild, 2004; Yeates, 2005).

From a micro perspective, the intense emotional pain of mothers leaving their children behind takes an unimaginable toll on children and parents alike (Bauer & Österle, 2013; Chang, 2000). Direct care workers are often breadwinners in their family, forcing them to be away from their families for years at a time, resulting in strained relationships with their now grown children. And direct care workers find that they are now closer to the children or elderly clients they care for than their own family members they have sacrificed and assisted all these years. Migrants often experienced being torn, referring to the blurring of identity, nationality, culture, and belonging. The emotional costs were unbearable for careworkers that have transnational care obligations of children or elderly parents (Bauer & Österle, 2013). The global movement of women is impacting family relationships and communities at home and abroad (George, 2005).

Hochschild's (2000) global care chain discusses the macro and micro implications of employing immigrant women to fill the care needs left unfulfilled by women in rich countries entering paid employment. Interestingly recent research has found that these immigrant women, now having entered paid employment themselves leave their caregiving duties to other women continuing a global transference of care to less advantaged woman at each stage (Yeates, 2005). At the heart of the outsourcing of care are implications of gender, class, and race divisions, leading the most disadvantaged to become paid caregivers (Yeates, 2005). The development of literature on global care chains is quite extensive with a special emphasis on nannies, but overall the research suggests a strong and increasing demand for migrant domestic workers throughout the

first world and a streaming supply from the developing world for childcare and elder care workers (Browne & Braun, 2008a; Chang, 2000; Ehrenreich & Hochschild, 2004; Parrenas, 2000; Yeates, 2005).

The exploitation of direct care workers is apparent in low wages and poor working conditions, resulting in half of direct care workers relying on federal public assistance programs (PHI National, 2011). Additionally migrant women are especially vulnerable to exploitation as domestic service is often paid under the table and local labor laws not enforced (Browne & Braun, 2008a). Domestic workers placed in private homes are particularly vulnerable due to the one on one nature of the work and rendered invisible to all but their employers and prone to exploitation because of race, gender, and class stereotypes (Bauer & Österle, 2013; Brush, 2007). In particular the stereotypes of caregivers that Filipino nannies love babies, English nannies are great disciplinarians, or Mexican housemaids are docile reinforces gendered and cultural notions of female caregivers from the developing world (Brush, 2007; Constable, 1999; Ehrenreich & Hochschild, 2004; Halliday & Smith, 1985; Maher, 2003). The "maid to order" mentality reinforces the cultural and historical stereotypes that undermines workers and violates worker and human rights (Constable, 1999). Pervasive gender and racial stereotypes fuel low compensation and assumptions of submissiveness of migrant workers, leading to high demand for migrant domestic help (Yeates, 2005).

Though Hochschild does not explicitly refer to the commodification of care in the global care chain concept, it can be inferred that the transference of care from specific socio-geographical locations in poor countries to that of richer countries speaks about the redistributive elements of the concept. Yeates (2005) emphasizes how the extraction of

care from poorer countries for consumption by richer ones constitutes the creation of surplus value and a major drain on the socioeconomic resources of poorer countries. Beyond the traditional notions of 'labor' and 'resources,' the psychological toll of transferring the emotional costs of long term separation from children and loved ones for financial gain are emphasized. Migrant women separated from loved ones for extensive periods may begin to transfer their emotional attachment to the children or elderly clients in their charge. In this way, global care chains are mechanisms of extracting "emotional surplus" suggesting that the Beverly Hills child is getting "surplus love" from their parents and from the nanny, who is separated from her own child to love (Hochschild, 2000).

The commodification of care work and its redistribution from family to migrant care workers is strongly determined by migration, elder care settings, and long term care regulations. Within this study, special attention will be paid to the notion of care from the perspective of immigrant homecare workers. The primary research question focuses on the care experiences of immigrant homecare workers. Caregiving theory will be used to guide the exploration of this question from several dimensions: the commodification of care; devaluation of care; and the challenges of outsourcing care to immigrant workers. Caregiving theory guides this project conceptually but it is expected the study will generate new data not previously found in literature.

Review of Literature

Few studies in the last twenty years studies' have examined the relationships between homecare workers and clients. Most literature on direct care workers focuses on

residential care settings and largely homecare has been overlooked. In particular, research on immigrant direct care workers is scant in comparison and most literature in this area comes from overseas. For this reason, this study will add greatly to the knowledgebase on homecare relationships, specifically with an immigrant caregiver workforce.

In this section, literature on three specific aspects of homecare relationships was explored: a) homecare as an ambiguous work setting; b) homecare is co-constructed; and c) homecare relationship patterns. The unique experiences of immigrant direct care workers were also examined. However since few U.S. based studies exist on this population, studies from other countries is primarily highlighted in this section. This section describes immigrant direct care workers' a) challenges b) rewards and c) examples of Israel migrant homecare workers.

Relationships between Home Health Workers and Elderly Clients

Home health workers provide hands on care to frail elderly in residential settings including bathing, dressing, or toileting and other instrumental care such as grocery shopping, housekeeping, and managing money. Beyond the technical aspects of care, the relationship between worker and client is a vital part of the care dynamic. However studies have pointed to confusion on the part of the worker and client on what it means to receive "care" within the home (Aronson, J. & Neysmith, S. M., 1996; Barer, 1992; Lindahl et al., 2011). Overtime, workers and clients mutually define the expectations and boundaries of the experience (Eustis, N. & Fischer, L., 1991; Lindahl et al., 2011; Neysmith,S. M. & Aronson, J., 1996; Regula, 2001). This results in greater intimacy in

the relationship that becomes like "friendship" or "family" for clients and homecare

workers (Berdes & Eckert, 2001; Karner, 1998; Piercy, 2000)

Home care as an ambiguous work setting

Home care settings have been difficult to observe and research on homecare

environments is sparse in comparison to research on residential care settings. The

homecare environment remains an ambiguous environment for workers and clients alike.

Expectations of "care" within a private home are uncertain when transference of care to a

paid worker occurs. The home is normally a private sphere, associated with privacy,

comfort, and control but ultimately changes when a worker enters to provide formal

services. Research has been struggling to define the boundaries of work in this case.

In homecare settings, workers and clients struggle to understand the dynamics of

paid care within a home. Studies described home care as a balancing act of power

relationships where workers are both empowered as caregivers yet disempowered when

adjusting to a client's home (Lindahl et al., 2011). Each time a worker enters a new

home, they must adjust to the norms, customs, and values of each client in order to make

clients feel safe and comfortable. The arrival of an anonymous helper may disrupt the

home as well as cause the client anxiety at the loss of privacy and independence (Barer,

1992). Home care allows clients to be empowered by continuing to live at home but also

disempowered by their disease/disability and dependency (Lindahl et al., 2011).

The balance of power and dependency is further exaggerated when roles are

uncertain in home care settings. There is no preparation for recipients of this kind of care

when for the first time, one sees see a stranger doing chores in one's home or provide

personal care such as bathing or toileting (Barer, 1992). The home care recipient may be

confused if he/she is the employer, patient, or hostess. Aides must delineate as to whether they are viewed as a friendly visitor, intruder, maid, or confidante. Home care workers are sensitive to this confusion and adapt to the household norms and values, becoming part of the informal social network patients and families come to rely on. Otherwise the disruption of routines and changing family interactions can create stress and a great deal of role conflict between aides and families (Lindahl et al., 2011).

Earlier studies describe the blurring between the formal responsibilities of the job and the personal attachments between the home care worker and client (Aronson, J. & Neysmith, S. M., 1996). While home care agencies tend to emphasize a professional worker client relationship based on boundaries, interviews with home care aides indicated a different paradigm and often they described the relationship as friendship or being like family. Closeness in relationships often led workers to go beyond their formal duties and felt a "call of duty" to meet the needs of clients (Aronson, J. & Neysmith, S. M., 1996). This reflected workers' moral commitments to meet the needs of vulnerable clients by doing unpaid favors even at the expense of going against agency protocol. Aides mentioned staying extra to sit and talk in the evenings, receiving calls on weekends when the client was alone or even providing gifts to clients knowing it was breaking agency rules.

Home health care is co-constructed

Though research on homecare relationships is limited, a few studies have focused on the relationship as a co-constructed experience. Studies shed light on how workers and clients mutually made efforts to build a relationship, and establish rapport and trust with one another. This involved clients sharing their preferences in receiving care. Workers

demonstrated an openness to be there for the client emotionally. Relationships evolved when workers and clients were willing to connect with one another on more than a strictly professional level.

An earlier study explored the nature and quality of relationships between home care clients and workers (Eustis, N. & Fischer, L., 1991). It was found that companionship was an expected part of the job and in many cases workers went beyond their required duties for clients. About two-thirds of aides reported doing extra services for their clients, while one-quarter stayed longer than they were paid. Clients often relied on them for companionship and socializing. For the oldest or most disabled clients, the home care worker was often one of their only social ties. Workers socialized with clients during their shifts and at times they would stay after their shift to keep isolated elders company. Overtime workers gained greater access to the private lives of clients which allowed for more personalized care but also necessitated going beyond their formal duties.

The process of helping was a complex and mutually negotiated phenomenon between the home health workers and clients. Neysmith and Aronson (1996) described immigrant homecare workers as drawing closer to clients when they had personalized knowledge of clients' preferences which allowed for adaptation of personal care. Helping was a multifaceted process that required observation, knowledge of the individual, respect for the self-determination of clients, and flexibility on the part of the worker. Homecare workers translated "helping" into personalized care which required nuanced skills and a great deal of effort on the part of the workers. The actual task of helping involved a great deal of unseen emotional skill.

Regula's (2001) phenomenological study on home care clients' perceptions of caring relationships occurred when workers were highly skilled in technical aspects of their job and emotionally available. Clients felt cared for by workers when they demonstrated competency in physical tasks (cleaning, meals, personal care), as well as the ability to relate to clients on a personal level. Workers that demonstrated all three characteristics including competency, emotional availability, and a positive attitude were perceived to be caring and generated a feeling of gratitude, happiness, and security for clients. Workers that were missing one of these characteristics were perceived as non-caring. "Caring" occurred when workers conveyed competence at their jobs and showed genuine concern for the client.

More recently, a meta-synthesis of qualitative research studies (*n* = 13) described and interpreted home health relationships as positive when mutual trust and solidarity developed (Lindahl et al., 2011). Relationships required mutual recognition of the knowledge and expertise of one another allowing for greater trust to develop between worker and client. It was especially important for workers to respect the self-determination of clients even if they could not understand the patients' reasons. Workers that engaged clients by slowing down, maintaining eye contact, sitting close to the client, and ending the visit when the client was ready, were able to engender feelings of trust and assurance in the relationship (Lindahl et al., 2011).

Homecare relationship patterns

Several studies have described patterns within home health relationships as either friendship or family (Berdes & Eckert, 2001; Karner, 1998; Piercy, 2000) . Beyond the professional relationship, the intimate nature of caring for elderly clients in their homes

allowed caring friendships to develop. Other studies have highlighted the process of becoming like kin or family, a deeply intimate and reciprocal relationship between client and worker.

An earlier study on relationship patterns found a three step process in becoming like family (Karner, 1998). Three stages of relationship development began with an introductory rapport building stage, deepened into sharing of selves, and finally the familial adoption phase. The introductory stage set mutual expectations and norms within the relationship. The second stage involved a deepening of the relationship where both parties received something more than caregiving or gainful employment, involving additional obligations and duties. The final stage is a deepening of the friendship into something like fictive kin. As the relationship progressed from each stage, the intimacy formed with one another could be perceived as closer than a blood relative or substitute for missing family relationships (Karner, 1998).

Piercy (2000) investigated the types of relationships formed between older clients and their homecare aides and discovered frequent descriptions of friendship forming. Conditions found to enable closer relationships included continuity of care provision, social isolation of elderly clients, and similarities of client and aide's race and gender. The process of friendship development began with the aide spending more time socializing with clients, leading to clients perceiving stability in the relationship and eventually self-disclosure, resulting in friendships to form. In particular, clients viewed extra unpaid tasks as tokens of friendship. At times, the relationship was found to go further than friendship to that of fictive kin (Piercy, 2000). Clients would call their homecare aides "son" or "daughter." Aides would refer to clients as "parents" or

"grandparents." Relationships grew into family-like interactions when clients and aides mutually self-disclosed and there was a reciprocal exchange of resources like the way a normal family may operate (Piercy, 2000).

A qualitative study with African American and immigrant aides within three nursing homes reported the use of metaphors to describe their affective care with residents (Berdes & Eckert, 2007). The language used by aides is most telling when describing emotional closeness and warmth to clients as either family or friends. Age differences of home health aides elucidated different metaphorical language. Older aides caring for those with Alzheimer's disease described clients as their babies or children. While younger aides described clients as their parents or cared for them like their parents. Use of such family metaphors fed their affective side which motivated some aides, especially instances when reciprocal caring was not present. Interestingly, the affective language was a form of coping for some workers, by calling clients babies or parents would soften the effects of racial abuse or difficult behavior of some clients (Berdes & Eckert, 2001).

Though the home care setting is initially an ambiguous work setting, over time the worker and client can mutually negotiate the helping relationship. The professional relationship transforms to that of friendship when workers and clients appreciate the companionship and the reciprocity from one another. In some instances family-like bonds were formed, creating intensely intimate interactions. The closeness in these relationships can cause a blurring of boundaries which leads to increased expectations of the worker and unpaid labor.

Immigrant Home Health Workers

Research on immigrant home health workers is very limited. Few studies have examined the context of home care and the dynamics of immigrant workers and clients. In order to increase the breadth of studies on immigrant direct care workers, studies on nursing home workers and research from other countries were also included. A thorough review of literature has found only a few internationally based studies documenting the relationships of immigrant long term care workers and clients. Studies have alluded to challenges and rewards specific to immigrant populations but a thorough investigation has not been done. Challenges related to language and other communication barriers, as well as differences in cultural expectations in care have been found. Increased discrimination towards immigrant workers was also prevalent. Overall indications on differences for immigrant workers have been alluded to but more research needs to be done on this area.

Challenges for immigrant workers

A recent study conducted in Ireland and UK nursing facilities with clients and caregivers found that migrant caregivers faced specific challenges in developing a caring relationship with an elderly client (Walsh & Shutes, 2013). Language and communication were significant challenges for older people and migrant workers. The social and conversational aspect of elder care was inhibited when communication was restricted, at times hindering social connections to form. Cultural differences dampened the development of a strong caring relationship, such as around customs or food preparation. Discrimination against migrant caregivers was commonplace. Incidents of discrimination might arise from the first interaction or later on with complaints about language

proficiency or issues around accents. The development of the care relationship was impacted by cultural misunderstandings and discrimination towards the migrant worker.

One of the few studies conducted in the U.S, interviewed residents and nurse's aides in four nursing homes to examine the effects of racial and ethnic differences between African American *(n=29)* and immigrant aides *(n=13)* from Africa, South Asia or Caribbean (Berdes & Eckert, 2001). Findings indicate that those who are foreign born face discrimination at an alarming rate. Eighty five percent of foreign born nurses' aides have experienced racism on the job either from clients, families, or their fellow staff (Berdes & Eckert, 2001). Foreign born aides were more likely to face racism than African American aides. Immigrant workers not only faced racism but also had to contend with xenophobia from their work peers and clients. Foreign born workers perceived that native born aides were afraid of job competition. Differences between immigrant groups were not detailed in this study.

However, Doyle & Timonen (2009) investigated differences between immigrant groups and found that African caregivers experienced such intense discrimination that morale and self-esteem were negatively affected. A comparative study of African, South Asian, and European migrant caregivers within the Irish long term care system (residential facilities, home health, and grey market) highlighted that Africans faced higher levels of racism or prejudice at the workplace. Perceptions of unfairness and discrimination highlighted unequal work relationships between white supervisors and black care assistants. Although African aides felt demoralized by the discrimination with peers and supervisors, they were also most likely to speak about the positive aspects of the job. In particular African caregivers valued the close inter-personal relationships

fostered with care recipients. The differences among caregivers' cultural groups are noteworthy: African caregivers experience specific challenges and rewards differently than other immigrant groups (Doyle, M., Timonen, V., 2009). Africans experienced greater discrimination in the workplace but they were also more likely to value their caregiving relationships as compared to other immigrant groups.

Rewards for immigrant workers

Though negative perceptions of foreign workers happen all too frequently, interviews with older persons receiving home care in Canada have also highlighted favorable perceptions of immigrants as caregivers. Clients view immigrant workers as better caregivers because foreign cultures foster more positive attitudes towards elder care (Bourgeault, Atanackovic, Rashid, & Parpia, 2010). Some mentioned that foreign born workers are much more committed to their job because they immigrated to pursue a better life and a pathway to success is working hard in one's job. Others felt that immigrants were more caring because they had been trained to do that all their lives in their families. Literature indicates that employers and care recipients construct racial stereotypes and have preferences for certain nationalities that they regard as docile, nurturing, and caring (Yeates, 2005).

Migrant homecare workers in Israel

The majority of scholarship on immigrant worker's experience in the home care setting is from Israel. With profound elder care needs depending entirely on foreign caregivers, primarily from the Philippines, Israel provides an interesting case study into the dynamics of carework with an immigrant labor force. A quantitative study examining 100 dyads of foreign workers and elderly clients in Israel explored the relationship

patterns and the factors that explain the patterns (Porat, I., Iecovich, E., 2010). The vast majority (61.2%) of the elderly perceived the immigrant home care worker as family and 17.3% as a friend. The length of the relationship did not impact the way recipients perceived the relationship, nor was language a significant barrier to establishing close relationships, contrary to previous research. The strongest predictor of a close relationship was perceived similar personal qualities between the client and aide. As most caregivers in the study were from the Philippines and homogeneity of workers and clients was not possible, similar values of piety and respect for older people promoted understanding between one another. Differences in language and culture were less of a challenge than previously described, and having common un-spoken understanding between foreign careworkers and clients led to the closest relationships. Though foreign workers enjoy inclusion into clients' families, studies also points to substantial emotional challenges as a foreign worker.

In one particular study of live-in Filipina caregivers, the authors described pervasive loneliness and social isolation of migrant workers separated from their loved ones and acclimating to a significantly different host culture (Ayalon, L., Shiovitz-Ezra, S., 2010). Filipina caregivers in Israel experience tremendous loneliness living apart from their husband and children. They also suffer from social isolation in the host country due to language limitations and cultural differences. This takes an emotional toll on workers, with some experiencing depression or crying spells and others having thoughts of suicide. Workers at times justified this emotional burden by reminding themselves that they are supporting loved ones back in their home country and providing a better life for their children. Many workers compensated for the absence of their family by becoming more

intimate with the clients and the clients' families. Though home care workers, family members, and care recipients portrayed the relationships as family-like, it was noted that Israelis felt that cultural, linguistic, or age barriers did impede developing close relationships (Ayalon, L., Shiovitz-Ezra, S., 2010). Though workers did not mention such barriers to closeness, they did describe uncertainty about inclusion into the Israeli family as it came at a price for them.

Another study described Filipino live-in caregivers' ambivalence becoming an honorary part of the client's family (L. Ayalon, 2009). Workers came to Israel to support their families in the Philippines and felt their attachments to their families were threatened over time, especially as they were integrated into the Israeli family as a surrogate daughter or son. Inclusion into the family meant that there was an expectation to perform duties like a daughter, with implications to provide greater emotional care as well as perform additional tasks without compensation. Migrant caregivers benefit from having a close relationship to clients, but additionally face challenges with unpaid emotional labor as well as separation from their own families.

Previous research addresses the complex nature of relationships between immigrant homecare workers and their clients (Berdes & Eckert, 2001; Doyle, M., Timonen, V., 2009; Walsh & Shutes, 2013). Cultural and linguistic differences between groups can challenge the development of intimate relationships. Dissimilarities in language, cultural mores, assumptions, or beliefs could impede communication and the closeness between clients and foreign aides. However, overwhelmingly clients describe their relationship to be family-like with their foreign aides. Though these differences may impede relationships to a certain extent, mutual understanding and common values play a

larger role on having a close relationship. Foreign workers suffer tremendous amount of loss as an immigrant. Discrimination and xenophobia (discrimination of immigrants) from their co-workers and supervisors take an emotional toll. Additionally the immense loneliness being separated from their loved ones is exacerbated by the social isolation that many face in their new adoptive country. The multifaceted experiences of a foreign home health workers are worthy of further examination. This study addresses these gaps in literature and describes the caregiving experiences of immigrant homecare workers. The following chapter details the data collection and data analysis of this project.

Chapter III. Methods

The main focus of the study is the caregiving relationship and the meanings the workers prescribe to them. Additional contextual information on work patterns and migration experiences were collected through interviews and political case studies. This study relied on caregiving theory to conceptually guide the formulation of questions and assist in data analysis (Appendix A). Also, migration literature guided the collection of migration histories of respondents. This chapter includes a rationale for the study design through discussion of the a) role of the researcher b) participants c) data collection d) data analysis e) data verification and f) ethical considerations.

Research Design and Approach

The conceptual framework for this study emerges from a qualitative tradition where the researcher is the primary key instrument that collects data from multiple sources and analyzes data from an inductive approach (Creswell, 2007). The focus of qualitative research is on the participants' meanings and builds on a contextualized holistic account of the problem. Qualitative research draws from naturalistic methods which study participants in their natural settings and attempts to make sense of the phenomena in terms of the meanings people bring to the experience (Denzin & Lincoln, 2005). This approach involves studying a smaller number of cases in order to discover patterns or themes and gain a substantive understanding of the central phenomenon. Creswell (2007) provides several conditions when qualitative research is useful:

1. When a detailed complex understanding of the issue is needed

2. To empower individuals to share their stories

3. To understand the context and settings where the phenomena takes place.

In particular qualitative description methods were carefully considered to be the best approach to illuminate the central phenomena for the following reasons:

a) Qualitative description presents factual information in everyday language by staying closer to the data and the respondents' words with less interpretation than grounded theory, phenomenology, or ethnographic studies (Sandelowski, 2000).

b) Staying close to the data allows for descriptive and interpretive validity when little is known about the population and there may be challenges to communication as English is a second language for some participants (Sandelowski, 2000).

c) The open-ended design of the study allows for discovery led by participants, giving voice to vulnerable low wage workers.

d) A rich description of the work setting and migration experiences contextualizes the central phenomena not otherwise known.

Other research designs were considered for this study including quantitative methods and other qualitative designs. However, due to limited *apriori* information on immigrant home health workers, predictive quantitative studies were not possible. The exploratory nature of the study, which requires open-ended questioning and discovery, required a qualitative approach. Other qualitative methods considered for the study, such as phenomenology or grounded theory, were not used due to the level of abstraction these methods employ. The phenomenologic approach moves beyond the stated and requires a deeper contemplation on what might be concealed in the responses (Munhall, 2007). Grounded theory involves analytical shifts from stated data segments, to abstract

categories, and eventually to a more theoretical level that involves a reduction of material (Munhall, 2007). In contrast, qualitative description methods focus on the content validity of data collected from participants where English is a second language, by staying close to the surface meaning of words in order to ensure the most accurate interpretations of the data. Qualitative description allows for interpretation of factual data and subjective data with little inference from the researcher.

The central phenomenon explored within this study is the relationship formed between an immigrant worker and their elderly clients. Several qualitative studies have investigated affective relations in carework (Anderson et al., 1998; Deutschman, 2001; Stone, 2000). However, there remains an absence of studies with immigrant populations which take into consideration the immigration histories of female workers from the developing world. Using qualitative description methods allows careworkers to voice their experiences with less researcher inference but also accounts for the contextual information unique to immigrants' social histories that have not been identified previously.

Role of Researcher

Qualitative research requires the researcher to use "self" as a primary research tool when investigating an experience. This typically involves a prolonged and intense engagement with participants. The research process requires the researcher to both convey neutrality yet also establish rapport with respondents. The qualitative researcher must reflect on his/her role in the inquiry process and be sensitive to their own personal biography and how it shapes the study (Creswell, 2007). The researcher from an academic setting is automatically in a position of power when researching vulnerable low

income immigrant caregivers. Though the researcher has every intention to work collaboratively with the aides, and use open ended dialogue to solicit the data, it is inevitable that issues related to hierarchy will arise.

"Otherness" is a barrier to understanding one another and reflexivity is required to unearth the underlying dynamics impacting the study (Fawcett & Hearn, 2004). It is hoped that special attention to language used within the study will allow the workers to feel free to speak their opinions and emphasize their power and influence in the long term care setting. This requires the researcher to practice self-awareness and neutrality during the inquiry process and convey honesty and openness with the aides. The researcher must be aware and acknowledge biases, values, or interests in the research topic.

Previously the researcher had experience working in long term care. Working as a clinical social worker with both the elderly and disabled adults with psychiatric disorders offers some familiarity with long term care settings. As an administrator and clinician with these populations, previous interactions with both family and paid caregivers occurred regularly. Additionally the researcher has volunteered for many years at a local nursing home facility. Professional aspirations to support disabled and elderly persons and their caregivers and encourage societal inclusion of these groups are a significant motivation to conduct the research project. It must be noted that based on these previous experiences, the researcher views homecare workers as an exploited and vulnerable group and is sensitive to the power and inequality dynamics underlying many of our conversations.

Similarly, personal interest in caregiving between immigrant workers and clients arises from an interest in highlighting the work of women. Previous observation of

devaluation of female caregivers has led to increased advocacy of the work of women and their contribution to society. The researcher's parental family history as immigrants has also fostered a desire to give voice to immigrant workers' experiences. Also the aforementioned social work practice experience allows credibility of the study as interviews are conducted with partiality yet the researcher is able to establish rapport and trust with respondents. The researcher's familiarity with long term care settings shapes the study and has led to a line of questioning that is likely to capture the caregiving dynamic between the aide and client.

Participants and Setting

The participants of the study are female immigrant home health workers within the Massachusetts area. Participants were selected through purposive theoretical sampling and maximum variation sampling. Teddlie & Yu (2007) described purposive theoretical sampling as a selection of cases that will best answer the research questions. Purposive sampling in particular allows for inclusion of cases that generated rich descriptions of what would be a typical case. Outliers were also sampled to provide contrasts with typical cases in order to highlight comparisons between groups.

A range of characteristics of workers were included in order to achieve a representativeness of the sample and set up comparisons between groups. The sample consisted of twenty-three female immigrant home health workers with varying levels of experience, education, and from diverse ethnic backgrounds. Selection was conducted through maximum variation sampling, which explores manifestations of phenomena across broad range of phenomenally and demographically varied cases (Sandelowski, 2000). Wide variations in the demographics of the aides are included, yet strengthens the

validity of the study when themes were identified that cut across group differences. Using maximum variation, the intention was not to generalize findings to all immigrant home health workers, but rather identify common themes with relationships amongst diverse caregivers. This approach allowed for variations in experience to be captured but also describe a core commonality in the relationality in caregiving.

Data saturation was reached when cases described a valid, meaningful, and insightful picture of the main phenomena. Saturation for most themes were reached after *n=13* interviews however data collection continued till *n=23* interviews to ensure inclusion of diverse variations on demographics of immigrant homecare workers. For the purposes of this study, maximum variation was guaranteed by including aides from different contexts:

1) Ages ranged from 28 to 68

2) Nationality from Caribbean or African nations

3) Years of homecare experience ranged from 3 to 21 years

4) Educational level ranged from high school to Masters.

Participants were selected to achieve a diverse sample based on age, race, country of origin, years of experience, and education. Rigorous inclusion criteria were met to ensure appropriate cases were included: aides with experience working within home health settings, employed through licensed home health agency for a minimum of a year, and hold a home health or CNA certificate. Additionally though English was a second language for some participants, only workers with proficiency in communicating in English (judged by the primary researcher) were included for this study. It is important to note that home health aides commonly worked within a variety of settings (home health,

assisted living, nursing home, hospitals) and within different roles (homemaker, Personal Care Attendant, Certified Nursing Assistant). Responses reflected their caregiving experience as a whole rather than a single agency setting or job title.

Recruitment of respondents was primarily through licensed home health agencies in the Massachusetts area. Agencies were selected based on their agreement to participate in the study and had an immigrant home health workforce that were employees of the agency and not privately contracted workers. Though workers were recruited from a specific agency, it is important to mention that many aides worked for multiple agencies simultaneously at the time of this study and their responses reflect their work experience as a whole.

Initial contact was made with homecare agencies over the phone. During these calls, the researcher described the specific aims of the study. Directors of homecare agencies were asked if the agency would be interested in participating in the study. If confirmation was received, a follow up phone call was made to agency directors to provide more details of the study. Agency staff began contacting their homecare workers to elicit interest in participating in the study. Fliers of the study were sent to the homecare agencies so they might hand out to their workers to encourage interest (Appendix D). Each agency referred a list of workers that showed interest to the researcher to make initial contact with workers over the telephone. The researcher carefully reviewed the study aims with potential respondents and reviewed confidentiality and privacy procedures. If the worker was interested in continuing, interviews were scheduled for one to two hours at a public library, and for the convenience of respondents, occasionally were held at a coffee shop, or private residence. Twenty-two

participants were recruited through four homecare agencies and one participant was recruited through another respondent.

Table 1: Agency Descriptions

Agency A	Employs 70 homecare workers (10 full time workers), has limited numbers of immigrant workers. Salaries are $14-15/ hourly, and no benefits. Services rendered are primarily out of pocket and only about 5% pay with insurance.
Agency B	Part of a national network of home health agencies, includes a Boston location that employs 145 home health aides (35-40 full time worker), most of which are from Caribbean and African countries. Salaries range from $14-$18 hourly, and benefits (raises after 1000 hours of work, subsidized health insurance and matching IRA funds) are offered though most do not take advantage of them. Services are paid primarily out of pocket and a few with private insurance.
Agency C	A medium sized care management and home health agency that employ fifty aides all part-time, primarily from Uganda and Caribbean to serve within their care management side of the company. Salaries range from $12-$16/hourly and no benefits are offered. Services entirely paid out of pocket. Shifts are at least 4 hours long but most are longer.
Agency D	Large home health agency that employs 149 home health aides (51 full time) primarily from African, Caribbean, or Eastern European countries. Owners are immigrants themselves. Salaries are $13-$15/ hour and benefits include a 401(k), subsidized health insurance, sick pay, and vacation time. Services paid through Elder Services, private insurance, Medicaid, and Medicare.

Data Collection

Interviews were primarily conducted at public libraries close to the respondent's home and on occasion at coffee shops or private residences. Before the start of the interview, respondents were given a flyer describing the project (Appendix D) and informed consent was reviewed (Appendix E) and they verbally consented to participating in the study. As English was a second language for some respondents, the researcher wanted to review forms orally so that respondents were aware of their rights as

participants. It was important the researcher gave time for the participants to ask questions in order to confirm understanding of the study aims and the risks and benefits of the study. As part of the IRB protocol of the study, it was deemed best to ask for verbal consent to participate rather than a signed consent as some of the immigrant aides have family members who are not documented and this may cause them to hesitate to participate. Consent was re-addressed throughout the study as participants benefitted from continuous reassurance their answers were confidential, especially from their homecare agencies. Interviews ranged from 1 to 2.5 hours, recorded with the permission of participants, and transcribed verbatim by a third party transcriptionist. Quotations from transcripts are extracted to reconfirm themes, show variation, and show richness of the dialogue.

The semi-structured interview protocol focused on three broad areas: caregiving experiences, migration histories, and work patterns. Interviews were guided by a list of original twenty open ended questions (Appendix B) focused on these three core research areas guided conceptually by caregiving theory. Sandelowski's (2000) seminal article on qualitative description served as the guide for data collection and analysis. Interviews and data analysis were conducted simultaneously for constant comparison. This allowed the researcher to be reflexive and interactive with the data by continuously modifying treatment of the data to accommodate new insights found during interviews. Interview guides incorporated both open ended questions that allowed for discovery of themes brought up by the respondent but also contained standardized questions. Initially, interview questions were derived from previous theory that pointed to salient themes related to the topic. This allowed for rigorous data collection procedure that maximized

interview time and offered consistency in the interviews. Additionally, open ended questions allowed the respondent to bring up issues or themes that were important to them which added a rich depth to the interviews that would not have been known had interviews been solely structured. Circular treatment between data collection and data analysis resulted in several iterations of the interview protocol until a final list of questions was created (Appendix C).

The interview style incorporated some prepared questions that allowed for systematic data collection and comprehensiveness of the inquiry but also included non-directive open-ended questions that encouraged respondent to largely determine the course of the interview. Thus participants were empowered to discuss issues most salient to them rather than topics chosen *apriori* by the researcher. Several interesting themes emerged when participants led the conversation and subsequent interview guides were modified to allow for constant comparison with new data.

Participant interviews were digitally recorded and transcribed by contracted transcriptionists. Verbatim transcripts including emotional cues (silence, laughter, crying) were created from digital recordings. A third party transcriber was hired to ensure accuracy and diminish potential bias during the transcription process.

After each interview, field notes systematically recorded observations of participants, interview setting, and personal responses of the interviewer. Researcher used a field notebook that included aspects of data collection from gaining entry into the field, interview process, observation of participants, and data analysis steps. Additionally, a memo document was created for each interview that served as a working document recording initial field notes, post interview reflections, data analysis notes, and a final

summary of each interview. These were incorporated into the transcription document for each interview. The data analysis program used was NVIVO 10, which allowed for a log of data analysis steps during the project which also serves as another source for the audit trail to be reviewed by the committee.

Data Analysis

Analyzing qualitative data is largely an inductive process. Although there is no one formula for transforming qualitative data into findings, qualitative description largely served as the organizing structure of the data analysis plan for this study. Data analysis for a qualitative study is an iterative process where data collection and data analysis are simultaneously conducted to allow for constant comparison. Creswell (2007) likens the process to a data analysis spiral moving in analytic circles between collecting and analyzing rather than using a fixed linear approach. The treatment of the data changes constantly as the study progresses and new insights are found. Future interviews incorporate new insights from the data analysis of previous interviews.

To assist in the data analysis of the interview data, NVIVO 10 software was used. Qualitative software offered several benefits to the data analysis process including 1) efficient method of organizing and sorting the data, 2) facilitating the accuracy of coding, 3) ability to write annotations, memos, and summaries linked to each interview, and 4) aiding in group comparisons. The following steps were undertaken during the data analysis of this study:

Table 2: Data Analysis Steps

Data preparation

Cross-check audio with transcript

Add respondent's emotions

Add annotations to segments of data

Link field notes and memos to each transcript document

Content Analysis

Add respondent demographics into content analysis matrix

Add factual data into content analysis matrix

De-contextualizing Data

Initial coding guided by theory and data driven

Initial operational definition of theme

Second coding, read through theme and delete or move quotes if necessary to better fit the operational definition of theme

Add themes into content analysis matrix

Rebuilding Data

Using the matrix, identify within and across case similarities and differences

Collapse or expand themes as necessary

Change operational definitions of codes if necessary

Changed Interview Procedure

After 3 interviews, determine if questions need to be deleted, added, or wording changed

Summary of themes

After completion of data analysis of all individual cases, add summaries to themes

Data Preparation

In-depth interviews were transcribed verbatim by third party transcriptionists that remained impartial and thus decreased bias during the transcription process. The principal researcher carefully cross checked the interview document with the digital recording to ensure accuracy. At this point emotive expressions were included in the transcript such as laughter, pauses, and crying to indicate the overall feeling of the interview. Additionally a memo was created for each interview document incorporating field notes, observations, procedures, personal reflections, and summary of each interview. Researcher read the transcription document several times in order to become deeply intimate with interviews and get an overall gestalt of the interview before coding. Brief notes, comments, questions, and personal reflections of large segments of data were added as an addendum to segments of the interview document and served as a guide while coding the interview.

Content Analysis

The researcher used a directed approach to content analysis, which was informed by previous theories guiding this study (Hsieh & Shannon, 2005). Existing literature helped identify some key concepts related to the study and establish operational definitions for concepts. However, as literature was incomplete on the subject, new findings gave a greater description of the topic. Content analysis of data also identified concepts that did not fit into previous theory. Within qualitative description studies, theories serve as the organizing framework for collecting and analyzing data, however if the data suggests a poor fit with the theories, the researcher will not force the data to fit *apriori* to the framework (Willis, Sullivan-Bolyai, & Knalf, 2012). Instead theories are used as a guide to the creation of relevant coding groups but also included emerging

themes found in the data. The following were the systematic data analysis steps carried out in this study.

The first step in qualitative description coding was to extract factual information that contains the least inference so that most readers will have interpretive consensus. After selection of factual information, thoughts, processes, and meanings were grouped into large thematic categories. In staying with qualitative description's purpose, coding stayed close to the surface of the respondents' words.

De-contextualizing the data involved using a directed content analysis approach guided conceptually by caregiving theory to identify some key themes found in previous literature as well as assist in creating operational definitions of themes. Initial coding step involved extracting factual data (time, place, and event) from subjective data (emotions, thoughts, memories). Large segments of the transcript were coded for emerging themes. Initial coding used previous theory as a guide for the initial creation of some codes. However large segments of data did not fit into previous theories and general categories were created to incorporate emergent topics. During this step the operational definition of themes were created.

The second coding step was to refine each code category. Data segments were reviewed within each code category and often re-coded or deleted to better fit the operational definition of the code. At times the operational definitions of codes were changed to better reflect the data findings. General categories of codes, also known as the parent code, were broken into child codes. For instance, the code "challenges" was found to be too general and segments of data were re-coded to code for instances of "discrimination" or "unpaid labor."

Rebuilding the data refers to examining within case and across cases for similarities and differences of themes. This allowed the researcher to gain an impression of the unique aspects of each case and a well-developed holistic account of all the cases. Rebuilding also involved re-organizing the data by rearranging themes to create a meaningful understanding of the phenomenon. Sub-themes were identified and collapsed under one parent theme such as "Specialized Skills" which included sub-themes "Being helpful" and "Empathy." Expanding themes involved deconstructing the theme further such as the Relationship theme was de-constructed into "Friend or Family" theme and "Respecting Elders" theme. With greater understanding of emerging themes, the operational definition of themes was changed to better fit the data.

Rebuilding the data involved entering coded data into a matrix analysis for further comparisons between cases (Averill, 2002). A descriptive matrix allowed categorized data to be displayed in individual cells. This was an invaluable way to systematically analyze the data for further comparison within and across groups. The researcher used the matrix analysis to identify similar phrases, patterns, themes, and sequences found in the data. The matrix was reviewed after new cases were added to get a sense of patterns in the data and signify typical cases. Matrix analysis aided in a constant comparison process between data collection and analysis as coded data was entered and often new insights not found in previous interviews were apparent.

Lastly, coding involved identifying both commonalities and differences within and across interviews. Both points of convergence and divergence in the data were important to understanding the phenomena. Data saturation was reached once codes were found to have consistent variance within the data. For instance majority of the

respondents found the inconsistent work hours difficult, but some respondents found themselves working too much, and others did not have enough work. Matrix analysis allowed for a systematic way to identify across group differences. Different age group categories were compared to identify if there were differing caregiving experiences across age groups. Finally outliers were easily identified, those that did not fit into the typical range of findings. One respondent differed from other respondents in her approach with clients to remain professional and removed from clients, while providing good care. Within qualitative studies, outliers serve to contrast the patterns found in the data and strengthen our observations of findings.

Changes to the Interview Procedure

The data collection and data analysis procedure was iterative. After analysis of three interviews, it was deemed that interview questions should be changed to better capture additional information about the emerging theme. At times some questions were deleted as they did not add value to the study. Interestingly, respondents re-worded some questions in ways that were culturally relevant or made more sense to them. For example the question "Do you ever feel other people don't respect your work?" was changed into "Do other people make you feel low about your work?" after several respondents re-worded their responses. The concept of being made to feel low was something that was more relatable to them, than not respecting them. Future responses to the new wording of the question elicited better responses.

Summaries of Themes

After the data analysis and data collection was completed for all cases, each theme was carefully reviewed to gather a gestalt of all cases. Quotes under the theme

were reviewed again for a final analysis of the theme. Additionally the content analysis matrix was reviewed to confirm similar impressions of the theme. Afterwards, final summaries were written on each theme and served as a reference during the write up of findings.

Memos

In addition to the transcribed interview document, memos served as a useful tool during the analysis portion. Memos containing field notes, post interview reflections, data analysis notes of the interview, and a summary of each interview. The researcher used memos as a process recording of the study in order to document what occurred and was found during interviewing and analysis. This allowed for contextualized understanding of interview findings that may have been overlooked if the interview document served as the sole source.

<div align="center">

Data Verification

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Credibility and trustworthiness in qualitative studies are enhanced by employing verification procedures. Rich narrative description found within the data allowed readers to also formulate conclusions about the data. Although qualitative studies do not deal directly with threats to validity, the proposed study will use several strategies to ensure the quality of the data and the rigor of the data analysis (Creswell, 2007; Lincoln & Guba, 1985). In this study, seven strategies were used to ensure the accuracy of this data (Table 3).

Table 3: Data Verification

Internal Verification
Reflexivity
Constant Comparison
Negative Case Analysis
Audit Trail
External Verification
Member Checking
Peer Review
External Audit

Reflexivity

The internal verification procedures began with the researcher practicing reflexivity throughout the study. An essential part of obtaining objective distance from the study is by "bracketing" or suspending natural assumptions in order to understand phenomena without prejudice (Husserl, 1931). Although complete suspension of our assumptions are difficult, an intentional practice of revealing researcher's background, past experiences, biases, prejudices, and orientations offered greater transparency to the study. Self-awareness was necessary to separating personal responses to the study from that of interpreting the content. Differences in ethnicity, race, education, and class between the researcher and respondents were apparent. However it was unclear how the respondents felt about the researcher and what assumptions and biases they held. It is anticipated that some discomfort was felt by respondents and researcher used a non-directive and submissive style of interviewing to encourage rapport building but also have conversations be led by respondents.

Constant comparison

The reiterative process between data collection and data analyses allowed for constant comparison between the data and interview process. During analysis, data was de-contextualized and integrated into meaningful patterns. The researcher checked patterns in subsequent interviews to see if the working hypothesis held true. This allowed emerging data to be compared to initial findings, and to expand the understanding of patterns further.

Negative case analysis

Within qualitative research, outliers or negative cases served the principal role of refining the working hypothesis. Rather than exclude negative cases, incorporating disconfirming evidence helped expand and test the emerging hypothesis. Researcher continued to revise the initial hypothesis until all or most cases fit and created a more holistic understanding of the phenomena. One of the first respondents discussed how it was particularly difficult during the beginning or end of the relationship. Other respondents did not identify this theme again and this outlier was absorbed into the theme "challenges."

Audit Trail

This study included an extensive audit trail from the development of the project, data collection procedures, data analysis steps, and formulation of findings. Memos were also kept on each theme detailing the working hypothesis from each new case.

Member checking

Lincoln and Guba (1985) consider member checks the most critical technique in establishing credibility. Researcher solicited participants' viewpoints on the credibility of

findings and interpretations in the form of follow-up phone calls. After the themes were identified, researcher confirmed understanding of these themes with three respondents. Quotes under each theme were read to respondents to confirm agreement on interpretation of the quote and confirm if this reflects their experience. In this way the respondents judged the accuracy and credibility of the account and provided the final word on the trustworthiness of the study.

Peer review

Within qualitative research, peer review during the research process increases the reliability of researcher's perspective. Peer review involved meeting with another qualitative description researcher not involved with this study to review the methodology of this project and discuss findings for the study. A peer reviewer was asked to enhance the accuracy of the account by asking questions about the method, meanings, and interpretations in order to provide an external check of the study. Researcher relied on peer debriefing and support to serve as additional sources to practice reflexivity and increase trustworthiness.

External Auditor

An external auditor provided an assessment of the research process and product of the account. The auditor had no connection to the study but assessed if the findings, conclusions, and interpretations were supported by the data. Qualitative description expert, Dr. Susan Sullivan-Bolyai was consulted from the beginning of the project and served as a mentor throughout the data collection and analysis of the study. Additionally Dr. Sullivan-Bolyai reviewed three transcripts to match the overall findings for this study.

She also reviewed selected quotes for each theme to verify internal consistency of the study.

Ethical Considerations

Naturalistic inquiry involves direct involvement and participation of the researcher as the main tool of data collection. Thus the research process involves navigating a complex dilemma of pursuing research aims while accounting for the vulnerable nature of extended face to face inquiry of immigrant low wage workers. Ethical considerations began at the very beginning of the formulation of the study, with the researcher assessing if the research problem would benefit the actual individuals being studied. Research serving a useful or generative purpose for the people being studied was deemed the most ethical.

The approved Boston College IRB consent form (Appendix E) detailed truthfully the nature of the study, the right to refuse participation in the study, procedures for the interview, confidentiality and privacy, and the right to ask questions. The consent form was read out loud to participants and affirmative confirmation of comprehension of content was collected due to the limited English comprehension of respondents. Special attention was given during this process and only verbal consent was requested as written signatures on the consent form made it unlikely and possibly unsafe for some to participate if they or their family members were not documented. The utmost care was taken to protect the privacy of these participants.

During the course of the study, participants were continuously informed and encouraged to be collaborators in the research process. A semi-structured interview format with substantial open ended questions allowed for the perspectives and opinions

of the people being studied to be highlighted in the study. The "voice" of low wage workers were considered important to capture and served as a cathartic experience for some. Researcher also strived to confirm interpretation of findings by checking back with members of the group. Rather than using *apriori* assumptions to be the main guiding feature of the study, those who were studied became the expert opinion in this case. The intention of choosing qualitative description method for the study was to account for English as a second language for some of the respondents and to minimize misunderstandings by the researcher by staying close to the surface of the words during the interpretive stage.

As home health workers receive hourly wages, their time is very limited and to participate in this study did involve a sacrifice of time. Researcher provided gift cards of twenty-five dollars for each interview in hopes to offset any lost wages or transportation costs participating in the study. Researcher anticipated the possibility of painful reactions arising from discussing sensitive subjects such as migration experience, discrimination or feelings of loss after losing a client. The last five minutes of the interview were dedicated to de-briefing and processing what just occurred during the interview and if they revealed being emotional or distraught, counseling referrals were made. Additionally a few days after the interviews were conducted, researcher contacted the respondent to express gratitude at participation of the study and inquire if they had questions. This post interview phone call was deemed important so that low wage workers would not feel exploited during the research process. This also allowed the researcher additional time to assess if negative feelings arose after the interview and to offer appropriate services.

Lastly, reporting of findings protected the identity of respondents as well as the agency settings they worked. As direct quotations from respondents were used in the findings section, the identity of the respondent and location of the interview were disguised.

Summary

Qualitative description is methodologically appropriate to describe the experiences of immigrant home health aides, in particular their relationality with elderly clients. The methods employed were designed to produce a rich description based on the experiences of participants as interpreted by the researcher. The decision to use qualitative description was based on the research questions, attributes of the participants, the experience of the researcher, and the audience of the study. Knowledge gained from this exploratory study provides a basis for future research. The next chapter discusses the findings of this study including African and Caribbean migration histories, work conditions, and caregiving experiences.

Chapter IV: Results

Participants

The participant pool represented a diverse group of twenty-three female immigrant African and Caribbean homecare workers representing maximum variation across a broad range of phenomenally and demographically varied cases (Sandelowski, 2000). The selection criteria were based on the following: a) country of origin b) ages c) years of work experience and d) homecare agency. Respondents were recruited through four homecare agencies. Twenty-three was considered an acceptable number of participants as each interview was information rich (Lincoln & Guba, 1985). Saturation on most themes was reached after N=13 interviews, however, the researcher continued data collection in order to reach maximum variation of sample demographics as represented in Table 4. Quotes have been de-identified and names have been changed to respect the confidentiality of respondents.

Table 4: Participants

Participant Demographics (*N*=23): 12 African, 11 Caribbean (7 Haitian)

	Ages			Education			Years Worked			Marital Status	
	>40	41-50	51<	High School*	Some College	Bachelors/ Masters	3-7	8-14	15-21	Married	**Unmarried
African	4	3	5	5	3	4	8	4	0	9	3
Caribbean	3	5	3	8	3	0	3	5	3	2	9
Haiti	2	2	3	5	2	0	1	3	3	1	6

*High school or less   **Divorced, single, widow
Aides have lived in the U.S. 4-38 years. 82% have children (but only 30% have children under 18).
African participants from Uganda, Ghana, Kenya, and Nigeria have not been listed due to small sample size.
Other Caribbean participants from Jamaica, Trinidad and Puerto Rico have not been listed due to small sample size.

Respondents are African and Caribbean immigrants that have lived in the U.S. between 4 to 38 years, an average of 14.5 years at the time of the interview. Forty-three percent of the participants were currently married, significant differences were found between groups. Seventy-five percent of Africans were married as compared to eighteen percent of Caribbeans. Overall 82% of participants had children, but only 30% had children under 18. All participants are documented immigrants that were legally employed at homecare agencies (naturalized citizens, permanent residents, those holding work visas or student visas). Undocumented workers and those having refugee status were not included in this study, though some of the participants did indicate that they may have come to the country as undocumented persons but by the time of this study they were here lawfully.

All participants met the selection criteria for the study. Participants identified themselves as immigrants. Two respondents were from Puerto Rico, a U.S. territory with the freedom to live and work in the U.S.; however respondents considered themselves as migrants to a foreign land with similar migration experiences as other Caribbeans. They were included in the study, as their experience in America was similar to that of other migrant workers that arrived legally. Respondents were employed at home health agencies for a minimum of a year, held a Certified Nursing Assistant License or Home Health Certificate, and presented a good grasp of the English language.

Though homecare workers were sought specifically for this study, it was common for participants to hold several positions simultaneously (CNA, home health, homemaker, personal care attendants) and work for a variety of long term care settings (private client, home health agency, assisted living, nursing home, or hospital). All home health workers

had lengthy work experiences ranging from three to twenty-one years, and an average of 9.5 years as direct care workers. As is the tradition of qualitative inquiry, their responses reflect an amalgamation of their experiences rather than a cross-sectional reflection on their current home health experience. Their responses are a culmination of their direct care work in a variety of settings over the course of their working lives.

Migration Experiences

Contextual Question: What are the migration experiences of immigrant home health workers?

Gaps in literature exist on the migration experiences of direct care workers despite growing numbers present in long term care settings. Before discussing the findings related to the primary aims of this study on caregiving experiences, it was important to gather contextual data on Caribbean and African migration experiences to better understand the migrant worker experience.

All twelve African and eleven Caribbean participants discussed similar reasons to leave their countries and migrate to the U.S. (Table 5). The primary reason respondents left their countries of origin in hopes of searching for a better life which includes educational or work opportunities, "*well, you know, when you're in Africa, you hear, like, Europe, America, is like heaven. So, you want to come and see what is it. And you come, and it's full of stress.*" Like many immigrants before them, they sought opportunities for themselves and their children that their home countries could not offer them. Respondents discussed similar pull factors found in literature including more employment and schooling opportunities in the United States. Push factors included political upheaval that forced many out of their countries and limited opportunities for

women, "*I wanted independence. I wanted independence and I'm happy I did get it (in America).*" Respondents immigrated between 1975 to 2009 with Caribbeans migrating earlier from the 1970s to 1990s and Africans arriving later in 2000.

Table 5: Migration Factors

Factors related to Participant's Migration to the U.S.

	# of Participants	Migration Factors
African		
Uganda	4	better life, resources limited, education, family re-unification
Ghana	3	better opportunities, abuse at home, family urging to move, family re-unification
Kenya	4	better life, education, resources limited, political asylum
Nigeria	1	family re-unification
Caribbean		
Haiti	7	better life, education, family urging to move, political asylum, family re-unification
Jamaica	1	more opportunities, family re-unification
Puerto Rico	2	better life, family re-unification
Trinidad	1	family urging to move

A common occurrence for respondents was hesitancy to leave their country, but they did so at the urging of family members already in the U.S. or in their home country. Ambivalence was very common amongst those who immigrated but were convinced to do so by their uncles, aunts, sisters, or parents. According to one study, more than 80 percent of immigrants from Haiti and other English speaking Caribbeans entered because they had family in the U.S. (DHS.GOV, 2007) Younger respondents commonly arrived when they were single, and married later on when they arrived here, and did not return to their home country for this reason. Other respondents joined their husbands already in the U.S. and began families here and did not return. It appears that family urging or family re-unification is the second most likely reason for an immigrant woman to immigrate.

Kinship networks continue to be important for them as many aides immigrated with their family or eventually supported their families to come over. Respondents kept close contact with their kinship networks through regular contact through text, email, and Skype phone calls. Though immigrant communities played an important role in their life, it was common for respondents to discuss pervasive social isolation. Thirty-six percent of Caribbean and forty-two percent of African respondents did not have family or felt socially isolated.

Unlike much of the pre-existing literature on nursing migration (AARP Global Aging Program, 2005) it does not appear that any recruitment practices specifically targeted these immigrant women as direct care workers. Strong community ties within the immigrant community enabled most respondents to find a direct care job shortly after arriving into the U.S. For these respondents, U.S. immigration policies and country of origin push factors played a larger role in their migration.

When immigrant women were asked why they became caregivers, they stated that many of their countrymen were already in this line of work and they found that it was an easily accessible job for a newly arrived immigrant as it does not take too much time or money to get started in the field. They believed that one advantage to direct care work is that it allows for better advancement opportunities into nursing and other health care jobs unlike other low wage jobs so it was favorable to factory jobs or housekeeping. Many of the respondents liked the idea of being a caregiver, one aide said she *"was surprised I got paid for this because back home you usually just help for free."*

After describing the challenges during their early immigration histories and continuing to face challenges as immigrant workers, respondents overwhelmingly agreed that it was a good idea for them to immigrate. Respondents recognized that their lives turned out differently than expected but they still recognized the rewards that may not have been possible if they stayed in their country of origin. The most specific reward was related to their support of their families here and those abroad they were able to assist with their wages from direct care work. In order to illustrate the varied migration histories that African and Caribbean immigrants have faced, two case studies of Haitian and Ugandan immigrants are provided below:

Haitian Case Studies

Of the twenty-three respondents in this study, the largest ethnic group represented was Haitians. All seven respondents immigrated between 1982 and 1999 during great political and social upheaval for this small Caribbean nation. These seven women described their enormous struggles to immigrate to the U.S. and establish their lives in the midst of the political turmoil back home.

Haiti was a former French colony that gained independence in 1804, but American fiscal control of the island lasted between 1915 to 1947 and this time period is regarded as an American occupation of Haiti (Hughes & Crane, 1993; Lennox, 1993). Followed by three decades of dictatorships from 1956-1988. During 1972-1982, 68,000 Haitians were admitted into the U.S. (Department of Justice, 1982) after thousands fled due to political oppression, economic deprivation, and famine (García, 1986). Many arrived by boats fleeing Haiti by selling everything they had including land, furniture, and livestock to pay boat owners $2200 for passage when annual per capita income was $220 at the time (García, 1986). During this time, U.S. immigration policy designated Haitians as economic immigrants and did not offer political refugee status making it difficult for Haitians to enter legally, which has been criticized widely as racist and discriminatory policy (Hughes & Crane, 1993; Lennox, 1993; Little, 1992) It was estimated that two-thirds of Haitian immigrants came through as undocumented immigrants through Miami and New York City. Under the administrations of Reagan, Clinton, and Bush, the INS adopted the "Haitian Program" policy, whereby undocumented Haitians seeking refugee status were singled out and repatriated back to Haiti without due process unlike any other immigrant group, creating a long history of antagonism towards Haitians (Hughes & Crane, 1993; Lennox, 1993; Little, 1992).

Garcia (1986) noted that the majority of Haitian immigrants were young women who were often employed as domestics. Within weeks of arriving, Haitian community would help these women find domestic work. Their primary motivation for female migrants was to upgrade the quality of life for their families and have economic independence. It is remarkable that many of these historical accounts still hold true for

the Haitian respondents in this study and reflect the struggles that undocumented persons or refugees endured in the 1980-1990s.

In the early 80s, two young single participants traveled across the Caribbean to join thousands of other young women entering Eastern United States as undocumented immigrants. Participants, Aimee and Kimberly attributed political turmoil and economic depression as reasons they left Haiti and searched for more opportunities elsewhere. Kimberly, at age 19, dropped out of high school and decided to immigrate because in her "*country, I heard a lot of things going on….there were killings, a lot of things going on there…and then I said, 'why don't I stay here for more opportunity, because there's a lot of things in this country, they don't have there. Let me come and stay here, maybe I'll earn more. And then I'll go to high school in here*." Aimee discusses how difficult it was to be undocumented and how she had "to fight" to make it in America, "*if you come in without any kind of papers, you have to fight for that, until you get everything you need in the country to be legal.*" Though she regretted her decision to come, she ultimately stayed to give her children a better chance at life and get a better education. With few opportunities as undocumented persons, they primarily worked as caregivers for private clients found through the Haitian community. Kimberly was referred by a friend to a private home health job and has worked continuously in the direct care field for 21 years.

In the 1990s, Haiti elected its first democratically elected President and Parliament. However that was short lived as a military coup in 1994 ousted newly elected President Aristide resulting in civil unrest until the U.S. intervened in 1995 by sending troops to Haiti. Later that year United Nations sent troops to support Haiti's newly elected President and Parliament. Haiti's small economy was the poorest in the western

hemisphere with a life expectancy of only 45 years of age (United Nations, 1999). A democratically elected government attempted to address these severe economic problems, with the assistance from IMF and World Bank structural adjustment loans, including policies to privatize state resources and liberalize the economy that drew widespread criticism from Haitians (Mobekk & Spyrou, 2002). Leaving Haiti further marginalized, little benefit came to the poorest citizens as 70 percent of Haitians lived in rural areas and agriculture received only 1 percent of the total aid distributed (Mobekk & Spyrou, 2002). With little social assistance to the poorest Haitians, many came to the U.S. as undocumented migrants in search of a better life.

During this transition stage of Haiti's history, five respondents immigrated to the U.S. as undocumented immigrants or political refugees. Bronte describes the political chaos of Haiti and how her life was in danger as a practicing attorney in Haiti.

> *When I was in Haiti, I was a lawyer, I saw things wasn't good in Haiti. So, every time I had to reverse some government issues, and then when you are young there, things wasn't good for you and everything. So, I ended up getting -- beat up and arrested and everything in Haiti. And then, so I decided, so it's time for me, I have to (go to America).*

Ultimately she left Haiti in 1994 and was one of the few who were granted political refugee status, despite an unwelcoming U.S. immigration policy towards Haitians.

Nastassia , age 37, was only 14 years old when she left Haiti at the insistence of family, "*Things were getting bad with the politics down there, the president, Jean-Claude at the time, with the Tonton Macoute, the fighting and stuff. So my mother didn't want*

me to come back." As a rising tennis star that represented Haiti in tournaments around the world, she quickly adjusted to American high school life playing at state tournaments and giving tennis lessons at country clubs. However as an undocumented person her opportunities remained limited even with colleges approaching her for tennis scholarships.

> *So it was a tough -- once I graduated, I had got a four-year scholarship for tennis. I couldn't go, because I was undocumented. And I didn't know to, you know, present these things to my coach to let them know certain things. I didn't tell anybody. Everything was like a big secret, like, "You can't let them know." But I wish I knew better. I could have, you know? So I lost all these opportunities and stuff.*

The difficulties of being undocumented and living as political refugees were undoubtedly difficult for them. However consistently, Haitian respondents agreed it was still better that they came and escaped the political and economic turmoil that plagued Haiti for decades after their departure.

Ugandan Case Studies

Four of the respondents were from Uganda and immigrated during the time period of 2003-2010. During this time, changes to U.S. immigration laws granting diversity visas to populations with less representation in the U.S. produced a surge of Sub-Saharan Africans immigrating to the U.S. the last two decades (Population Bulletin, 2007). The diversity visa program tended to attract African immigrants that were well educated and highly skilled due to the high costs, difficulties of immigrating, and lengthy travel

(Population Bulletin, 2007). Ugandan respondents with the exception of one arrived with a Bachelor's degree, a marked difference from Haitian immigrants many of whom arrived in their teens with a high school education or less. In general, more than one third of African immigrants have college degrees and have more impressive credentials than Caribbean immigrants, as well as African Americans and non-Hispanic whites in America (Population Bulletin, 2007).

Despite African immigrants' high education and professional experience before immigrating, they experience a downward mobility in the U.S. and are not earning incomes or holding jobs commensurate with their backgrounds (Population Bulletin, 2007). Three of the Ugandan respondents worked full time or more as direct care workers while enrolled in higher education institutions. This reflects Africans' typical route to come to the U.S. (Population Bulletin, 2007). Though respondents alluded to difficulties in Uganda, they were reserved about sharing specifics of their history and in order for the researcher to be respectful of past trauma, historical records were used for the political history of Uganda.

Uganda is a former British colony that became fully independent in 1962. Since that time, a dictatorship (1971-1979) and several rotations of ruling parties (1979-2000) left many of Uganda's population struggling. A devastating legacy of the Second Congo War (1986-2006) by the Ugandan rebel group the Lord Resistance Army (LRA), led by Joseph Kony, is cited as one of the oldest, persistent, and violent armed groups (U.S. Department of State, 2012) that left Uganda devastated. At the height of the conflict, nearly two million people were displaced from their homes in northern Uganda (U.S. Department of State, 2012) and 66,000 children were abducted and forced into the ranks

of the LRA (UNICEF, 2006). Since LRA's retreat into the Democratic Republic of Congo in 2006, northern Uganda has had significant positive transformations, yet the lingering effects of such a devastating period of history undoubtedly leaves a mark on its people.

The four Ugandan respondents immigrated during the last stages of conflict and arrived to seek opportunities unavailable to them in Uganda. Jane at age 49 immigrated to the United States in 2003 and quickly found work as a babysitter and later on as a home health worker. She describes the downward mobility of new African immigrants, "*it's not easy to get other jobs even if there are people who come from home like they were accountants at home, they were bankers working in banks. But when you come here, it is easy to get this type of job (caregiving) than other jobs.*" Immigrants' transition can be extremely difficult and Debbie, age 28 was profoundly sad and tearing up as she described the loss she felt, "*It's...I don't know. We all have to make decisions, tough decisions for the people we love or for ourselves. But it's hard to move from one country and go to another, and begin a new life from zero.*" Debbie retold the hiring discrimination she faced during interviews in the hotel and restaurant industry despite her Bachelors in Hospitality, eventually finding low wage work as a housecleaner and airport clerk, before finding her way to direct care work.

Ugandans shared similar reasons as Haitians for immigrating, as they came in search of better opportunities and to escape conflict back home.

Because like in most African countries, jobs are limited. Most of the resources are limited there, not here. The facilities are not good. Resources are not good.

And there are so many people sharing the few resources, yeah, so you know,

conflict arises, so many problems arise. So much as you miss your people at

home, you cannot do much. Because some of us we are here, we have people we

help back home. So you just have to go on.

It was not uncommon for Ugandan immigrants to arrive with higher education degrees

and professional aspirations in mind. Three of the respondents already held Bachelor's

degrees from Uganda and were pursuing Master's Degrees in the U.S. to become health

care professionals or get their MBA. Before the interview, Ina was finishing preparations

on her last final and exuded relief and excitement over her graduation in a few weeks

with a Masters in Health Administration and Heather was additionally excited to receive

her MBA and to join her husband in Canada after graduation. Unfortunately it appears

that Uganda, with an ever increasing educated middle-class population without

employment opportunities, will result in an exodus of capable workers.

The case examples of Haitian and Ugandan immigrant experience illustrate the

difficult conditions that many lived in prior to leaving their countries of origin. The

political histories of many Caribbean and African countries have created a strong push of

working age women out of their countries in search of greater stability and in pursuit of

opportunities for themselves and their families. Though many have remained in direct

care work longer than they would have expected, many have been able to accomplish

important things to them, such as sending their children to college and sending substantial

remittances to their families abroad to continue their education as well.

Work Patterns

Contextual Question: What are the work patterns of immigrant home health workers?

Work patterns of immigrant home health aides are unpredictable and unstable. Seventy percent of participants in this study had a dichotomous problem of either being underemployed or over employed (more than full time). Others felt their hours met their needs: either work schedule was stable or family responsibilities/health concerns required less than full time employment. Those that were over employed described working a full time position within an acute or long term care setting in addition to working part time in a home health position to supplement their income.

A pervasive experience for immigrant home health workers is the instability and insecurity of their jobs as hours were not guaranteed by home care agencies and they found wages were too low for them to live on. Eight of the aides during the time of the interviews were waiting for assignments and struggling financially. A 57 year old Ghanaian aide, Mary described that "*since (losing a client months ago) I have never had a permanent job. Fill in for somebody but that's all….So at times, I'll be there for more than a month or two without work.*" Like many of the underemployed participants, Mary was appreciative when given the $25 dollar gift card to the grocery store for her participation in the study, relaying that she is "*now able to go to the store today*."

Due to the uncertain nature of this work, many aides overworked in order to save for when they would not have enough hours. A 35 year old Ugandan attended graduate school full time while working in a nursing home and as a home health worker. It was a challenge for her to balance all the responsibilities but she felt she needed to work "*multiple jobs to make ends meet. You can't have one job. You can't make it because it*

doesn't give you the stability. Would have done one job but the stability is not there and the pay is low. So you have to work different jobs to be able to pay your bills." Aides described working at a variety of direct care jobs, not being selective necessarily about the setting but trying to patch enough hours to meet their needs. They worked incredibly long hours, sometimes 12 hour shifts at a hospital and then an overnight shift or a full five day 24 hour live-in position, only to go to their second job on the weekends. If aides had other responsibilities such as young children or they were attending school, remarkably they balanced all these responsibilities precariously on their shoulders while providing care to disabled elderly.

The changing nature of workers' schedules made it difficult to generalize the number of hours worked and clients they had on a weekly basis. Some had stable working conditions with two long term clients for several years that equaled full time work. Others worked shorter shifts, 2 hours with each client resulting in working for more than twenty clients a week. And due to the frequent relocation to different homecare agencies, it was also difficult to generalize the impact of a particular homecare agency's culture or policies on work patterns. Table 6, illustrates a cross-sectional view of work patterns of respondents: those that were under-employed, over-employed, or had stable hours to meet their financial needs. Many respondents worked at a variety of work sites including other home health agencies, hospitals, or nursing homes. While other respondents worked solely at one home health agency. Clients spoke about their homecare experience in its entirety and work patterns reflected an ever uncertain, revolving experience of getting acquainted with new clients and new homecare agencies regularly.

Table 6: Work Patterns

Cross-Sectional View of Work Patterns of Immigrant Home Health Workers

	Multiple Sites	One Agency
Under	4	4
Over	7	1
Stable	2	5

Generally homecare agencies had little contact with aides unless specific issues arose about clients. Homecare supervisors, social workers or nurses met with the elderly clients briefly, conducted an intake and created a care plan for the client. Aides were generally left on their own during the implementation of the day to day care. Aides did not have a lot of interaction with agencies. For example, one aide stated:

> *I don't have relationship. Because since I need something I just call my case manager… Manager or boss, supervisor is the same thing. Never need to be close, because you know what, it's not your friend. They just need you for your job.*

In general participants liked less supervision and several mentioned that home health work was preferable to nursing homes because of the autonomy it offered, yet they would have liked a sense of protection when they were working in client's homes in case anything goes wrong or workers were unfairly treated. Workers often described that homecare agencies took advantage of them and did not give proper compensation or recognition for expertise in caregiving. A 28 year old Ugandan woman found agencies to be over charging clients for weekend coverage but did not pass this raise onto her, "*I found out they were charging the client more money for the weekend because it's the*

weekend, and they were paying me just like everyone was working there, which I find unfair." Overall respondents described feeling disrespected and their contribution was not fairly recognized.

Work patterns of immigrant homecare workers reflect an unstable and insecure work life. Respondents worked a variety of home health and CNA positions to have enough hours to meet their needs. It was common for homecare workers to be precariously under employed waiting on more work assignments or overwork by taking on a full time job at a nursing home and working part time in home health. Generally workers did not have positive perceptions of homecare agencies and felt disrespected and unfairly compensated, though there were exceptions of experiences where they felt loyal to the agency because of the genuine relationships they formed with supervisors.
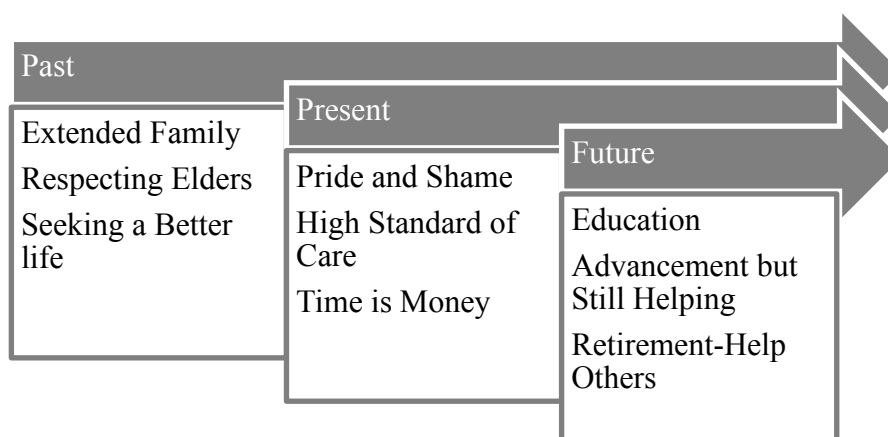
Caregiving Experience

How do immigrant home health workers describe their caregiving relationships with clients?

For this topical area immigrant home health aides were asked about their caregiving relationships. Asking this question in an open-ended fashion elicited rich descriptions of their perceptions of caregiving and what this experience means to them. Respondents had a nuanced understanding of their experience as the average worker had been in the field 9.5 years. Overall respondents described the formulation of caregiver identity overtime. Respondents discussed what caregiving has meant to them in the past in their countries of origin and related their values to familial caregiving experiences. Presently, respondents discussed their paid caregiving experience by exploring their conflicting feelings about their work and the meanings they attribute to caregiving.

Lastly, respondents discussed their future aspirations, often related to continuing in caregiving. Figure 2 depicts the three main categories of caregiver identity formation represented in chronological order of a) past; b) present; and c) future.

Figure 2: Caregiver Identity Formation

Past
- Extended Family
- Respecting Elders
- Seeking a Better life

Present
- Pride and Shame
- High Standard of Care
- Time is Money

Future
- Education
- Advancement but Still Helping
- Retirement-Help Others

Past

The past refers to respondent's experiences and values before they became a paid caregiver. Caregiving experiences began earlier within their families and countries of origin. Their understanding of being a caregiver and their first experiences in the role of a caregiver happened within a familial context in a culture different from that of America. Nearly all aides described caregiving experiences within their large extended families or communities. Caregiving was provided within the extended family, and as one 35 year old Ugandan aide described caregiving as "*a natural thing to do because you grew up in an extended family where tasks were given. So you grew up knowing how to do your chores. Or when your sister or your mother or anybody felt sick you're expected to take care of them. You weren't supposed to be asked. You were supposed to take care of them... how I was brought up probably contributed to the caregiving nature I may say.*" Caregiving was a communal responsibility and if a woman was unable to do so, she often

found another member of the family or neighborhood to help. A 61 year old Kenyan aide described "*I had my grandma. I was taking care of her. Then, my parents, like my mom was old. My -- For myself, I did not take personal care with her, but I got somebody to take care of her, and -- because I was working. Yeah. So... And in the -- We had a group from the church where we could go and visit the old people.*"

Aides described caregiving as both natural and expected, especially when it comes to caring for the elderly. Elderly were seen as part of the community and therefore elder care is provided by the community. Respecting the elderly was clearly a cultural value immigrant caregivers valued greatly and learned when they were younger and still practiced in their paid caregiving positions. A 28 year old Ugandan respondent described her previous caregiving experiences within her community and how she continues the same behavior with clients today.

> *And the culture where I come from, we respect the elderly, plain and simple…You know in the neighborhood there's an older man. You cook food from your house, bring him lunch. So I've kind of brought that with me, here, and I think even in the first few times, it was hard to accept the fact that, OK, it's my job and I get paid for it…I mean, I don't know how to explain it, but I feel like sometimes I change the location of where I am --but I still am the same culture that I was raised with. Sometimes, because where I come from, we kneel before elderly people, sometimes I find myself talking to these clients, sitting in their chair, just kneeling beside them, listening to what they are telling me.*

Her value to respect the elderly and include them into the community was so innate she found it surprising to be paid to do this but also that she is practicing her cultural values far from home.

A 39 year old Kenyan homecare worker described learning to unconditionally respect the old in their culture, "*It's in my bloodstream. (laughing) Yeah, just respect them. Even if some things don't make sense, you just do it as long as they do not pose a danger, yes, on their well-being…Yeah, they are to be respected. They've seen a lot… It's only old age is robbing them of their ability to do so much, yeah.*" The inherent respect and dignity they afforded their clients despite their disabilities allowed aides to separate declining abilities and mental state from the person.

Lastly respondents spoke at length about their desires to leave their countries of origin to seek a better life. As illustrated in the previous section under migration experiences, Caribbean and African aides attributed seeking a better life as the primary motivation for migrating. Seeking a better life included seeking political safety and pursuit of educational or vocational opportunities for themselves and their children. Fifty-seven percent of the respondents were unmarried and they were the sole breadwinner in their family. Though their wages were limited as direct care workers, it was very important to the participants to send as much as they could afford to their extended relatives. Being financially independent and sending back remittances were discussed as the primary reasons why they pursued direct care work and continue in this profession. Respondents were able to create a better life for themselves and their families here and abroad through their direct care jobs.

Present

This section explores their present experiences as paid caregivers. Respondents had a wealth of homecare experiences, between 3-21 years of direct care work experience. Their answers reflected a well thought out understanding of caregiving and their efforts to create meaning out of the caregiving experience. Three themes captured distinct aspects of the homecare experience: a) pride and shame depicts the emotional struggles they have as caregivers; b) high standard of care refers to their meaning making about the caregiving experience' and c) time is money is about the hurried existence they live as immigrant caregivers.

Pride and Shame

Pride $\longleftrightarrow$ Shame
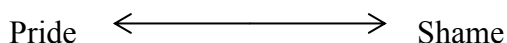
Respondents commonly felt two opposing emotions about their paid caregiving experiences. Simultaneously, respondents felt their efforts as a caregiver were a source of positive feelings such as pride in their work and being able to help others but they also struggled with feelings of shame at being openly disrespected and devalued as a caregiver. Connecting with clients and providing assistance to vulnerable elderly tapped into a very compassionate part of the homecare workers. They easily smiled and laughed when describing this aspect.

Silvia, a 47 year old Puerto Rican home care worker, walked into the interview dressed entirely in red and she exuded such pride and confidence in her work, "*I always try to do the best for people who need me and that's made me feel like I'm a good one. I'm doing the way and things, the best way and the right way. So when I leave that*

person, I always pray to God to take care of them. I know they're going to be by themselves....And like I say, I feel one in a million. I feel myself one in a million…"
Equally Bronte, a 44 year old Haitian worker, exuded such joy when describing when taking care to do *"the best job, because when I've done my job, always like I finished bathe the client, take care of them, dress them and everything. And then when I finish, and then I took two steps back, and then I look at that patient, and I say wow, this is my art. I do something, it's like you've got a card in front of you and then you paint it, and then they say wow, this is what I'm doing."*

Understandably homecare workers found it difficult to be devalued though they felt a great deal of satisfaction and pride in the work. When they described instances of being disrespected or discriminated against, many cried tears and showed distress in their faces. Debbie, a young Ugandan woman carried herself with a great weight on her shoulders during the whole interview, crying several times as she described the struggle to find dignity when others devalued her as a homecare worker,

> *"Yeah, I mean, I would think that this kind of job, that society will need me and would realize how much I contribute to it by doing this kind of work...It was so mean what this guy said to me. Like, we come from our countries to wipe ass and that our job and that's what we do… I mean, it's funny because the way I do my job, I would feel I should be proud and talk about it, just be excited about it, but I don't. And I mean, like, I don't think about it that way, but yes. Even half my friends don't know what I do. It's funny, I have never thought about it like that. But the fact that I have not proudly talked about it really, really means that it hurts that people don't value me."*

Irma a well-educated and thoughtful respondent with plans to work in health care

administration described her experience as a direct care worker enlightening and

hopefully exposed her to the value of everyone's contribution in healthcare because to

her "*respect, respect, respect is very important to anybody. Whether they're doing a*

lower job than you are, respect is very important. Like everybody is important in their

job. If they weren't, then nobody would be doing that job. So it's -- everybody is

important."

Respondents simultaneously felt very proud of their caregiving efforts to provide

good care and be a compassionate helper, but also felt a great deal of shame at the

disrespect from society for caregiving. This profound struggle led many of the younger

respondents to pursue higher degrees to get higher paid jobs. Remarkably it remained in

health care as they did not want to stop being a caregiver but to get more pay and

recognition.

High Standard of Care

When respondents were asked to describe their caregiving relationships inevitably

the discussion evolved into how they found great meaning when providing care to others.

Respondents easily brought up what motivates them to provide good care and this was

usually related to their values and experiences from their countries of origin. Providing a

high standard of care involved having significant motivation to be a good caregiver and

strong specialized skills to be able to help others. According to immigrant home health

aides, high standard of care is possible when a) workers have specialized skills; b) close

relationships like family or friendship; c) a moral calling to provide good care; d) caring fills the void in one another.

Specialized Skills

Specialized skills refers to a skill set that enables home health workers to work with clients effectively: empathy, patience, kindness, making others feel comfortable, humor, and persuasion were some of the skills that respondents brought up. Ninety-one percent of respondents made references to specialized skills when providing care for others. Empathy and patience were the most common skills mentioned. In particular empathy and patience was described as the core of caregiving, a way to understand a difficult client's behavior or empathize what it would be like to have a stranger come and care for your body and home for the first time. Jane, 59 year old Ugandan respondent could see how clients perceived her as intruding into their space, "*you have to sort of imagine that if I were to put myself into her shoes, like she's old, they have brought her somebody in the house, a new person, she has never met before. Sometimes you have to think try something if I were the other one, maybe you just let it go.*"

Aides used a variety of empathic skills in order to relate to clients including those with severe cognitive impairment. Certain skills were employed when clients were being difficult or anxious. One skill is best described as being submissive (keep quiet, calm, and low) which allowed anxious clients to calm down and not be threatened by the aide. Aides used empathy with clients often citing dementia or the natural process of aging, and the loss of independence as primary reasons clients were mean or difficult rather than clients are observed as resistant. Such a perspective allowed aides to be patient, they were able to hide that they were annoyed or angry but exhibit calmness and quietness and that

they were listening. This allowed already anxious clients to feel that they were not threatened by the worker but they were there to help.

Persuasion was a very important skill that many respondents used, a toolbox of different strategies for different clients' behaviors. Gina, a highly skilled 35 year old Ghanaian aide described her techniques on motivating a particular resistant client, "*and I have a trick of ways of . . . Sometimes it's not the Parkinson's, sometimes it's psychological. It's the way you talk to him. The way you treat him. It lessens the anxiety. And his wife don't know how to handle him. Because . . . it's the way you talk to them.*" Though aides tried to persuade clients, they were also keenly aware to respect the client and this superseded any desires to get clients to perform tasks against their will but rather encourage clients to have a say in their care. Aides often introduced a topic of a shower or eating lunch well in advance and would have to revisit the topic 3-4 times before clients would agree to the task on their own. Having a closer relationship with the client and personal knowledge of client's preferences was important to providing personalized care. Helping eventually evolved into caring about the client and encouraging them, as one aide described that it was important "*to talk to them, give them hope, that life still exists.*" Aides were friendly, smiling, and used humor to engage with clients on a personal level.

Karma

Karma refers to workers' desire to treat clients the way they or their family hoped to be treated someday. Seventy-three percent of participants spoke about aspects of karma, especially related to when they aged or when their parents needed care. It was common for respondents to correlate how they treated their clients to how their parents

are treated by their caregivers back home. Faith, a 55 Ghanaian homecare worker

believed that "*you can't abuse your own mother or father, so why should you do the same*

thing with another parent? No, you don't have to do that. And even if you see someone

abuse it, your parents, will you be happy? I mean insulting your parents, no. They won't

be happy. So why shouldn't you do the same thing with your clients?" She herself hired a

caregiver for her father, and "*you don't know what is going on back home. Like, your*

father is sick, and then they ask somebody, like, a nanny to take care of your father."

Many of the respondents shared that their Christian faith motivated them to

provide good care in case something negative comes back to them. "*Because I'm a*

Christian, always say, if you've done something to someone, don't worry, it's going to

come back to haunt you." But they also expressed the care they might hope to receive,

"*and I said, maybe I might become older. You never know. I like to treat them the way I*

would like to be treated in the future." Overall respondents seem to have a strong sense

of repayment for their good or bad deeds as a strong motivator in providing good care to

clients.

Friend or Family

Friend or family refers to how clients and workers referred to one another,

indicating the deep interpersonal relationships that developed between them. Ninety-five

percent of respondents thought of clients as friends or family, relaying deeply personal

accounts of their relationship. Jane was very moved and smiled gently when

remembering the relationship with her first client, "*she was a very good lady, she could*

treat you like a real friend, a sister. The relationship was so good, she could trust you,

because you could stay two of you in the house. Yeah, the first client, I really liked her so

much. She treated me like a sister." One aide put it best that thinking of the client as your "person" made it easier to do the dirty aspects of the job or to understand difficult behaviors from clients. From this perspective it moved the job away from the grind of daily chores into the personal, a caring space where the interaction could be meaningful to aides, "*we have bonded and we have become like family.*" Aides often thought of clients like their parents as their culture dictates to respect the elderly and include them into the community. Rather than seeing the client as dependent, this perspective allowed an honorary place in their minds where they were the younger person that showed respect and obedience.

Caring Meets a Need

The caregiving relationship was a deeply meaningful experience for the client and the worker that fulfilled a need in them. Sixty-five percent of workers mentioned how the work was much more than about receiving a paycheck, "*I think I really genuinely care so much about people. And for me, it's not only about getting a paycheck, it's about making a change in someone's life….But for me, it's more like I love taking care of people. I just love making a difference in their lives.*" It was a very rewarding experience for workers and they made great efforts to leave the client off a little better.

> *Mostly I would like them to know that it's not all about money. It's more about caring and giving other people assistance and giving them hope. Making them happy. To feel that we, you know, to feel that, you just when you walk in there and you come out of there, let them feel that she's somebody you know? Yeah, although their families are far away, their children are far away, let them just feel*

that while you are there, they have somebody. You make it part of your job. Let it

be a job whereby you walk in and you walk out happy and you leave them happy.

Caring for clients was also a way for immigrant workers to fill a void or longing they had because of the prolonged separation of loved ones, "*It's strange, because it kind of feels like you have moved into this country, you probably left everyone you care about back home. So it sort of feels like you are giving them all this love you would have given your loved ones.*" For some who immigrated without family, they found that clients could be like family to them, "*when you move -- when you transit from somewhere else, definitely it's gonna be lonely for you if you don't have family, you know. If you can get a job, and you get a job as a caregiver, you find family in them. You know, you find family in them because you're with them, most of the time.*" Caring was ultimately a rewarding experience for workers and clients. Workers made great attempts to address unmet emotional needs in clients. For some workers caring also filled a void left in their lives when they immigrate without family.

Respondents described several dimensions to providing a high standard of care related to the meaningfulness of the experience. Immigrant home health workers informed by their sense of right and wrong reiterated that karma motivated them to treat clients the way they wished they or family would be cared for. Additionally the intimacy they formed with clients akin to friend or family was a genuinely meaningful experience for them. Caring ultimately filled a void in the clients and workers' lives where connecting made isolation and loneliness easier for both groups. Lastly, a high standard of care would not be possible without "specialized skills" of the worker such as patience and empathy.

Time is Money

The final caregiving theme is "time is money". This concept refers to the hurried existence that immigrant workers live taking in as much work as they can in order to make ends meet. The hours of homecare work can be unstable and the low wages forces workers to work as much as they can, often working more than full time. This is the only way they can assuage their persistent worry that they will not be able to meet their needs. For those who are under-employed, they are overwhelmed with worries, "*when I'm not working, I'm crazy, like when my client go to vacation for month, or two months, and I have -- I'm not working for 40 hours, no 60 hours for two weeks or something like that, oh, I'm crazy because I have no money. (laughter) No, this job doesn't have vacation pay, no, we don't have vacation, we don't have nothing. You can have healthcare, but you have to pay for that.*" (Haitian, 62).

Immigrant direct careworkers found the hurried pace of life in America to be difficult to adjust to. Life was so hurried in comparison to where they came from and they found themselves counting hours, even minutes they were working. Naya (Haitian, age 37) described that "*foreigners will definitely tell you time is money…. Yeah, yeah….Right. Right. Right. If you're not doing anything with your time, for example, you work--, you could call them and tell them you need hours, so time is --money. You have couple hours free and you want to do something with it, you could make money with that.*" Workers planned for times when they would not receive steady hours or for emergencies that their extended family might experience abroad, which was common.

The majority of respondents (57%) are the sole breadwinners here in the U.S. and also contribute to the needs of their families abroad. They not only felt the weight of

making sure their needs were met but also felt the dual pressure to make sure there was enough for the needs of their extended family. As Debbie, (Ugandan, age 28) described the chain of those depending on her,

> *Home health aides, most of them, live a very, very unsettled life. And it's scary because this is their source of income and many people depend on them. It's like a chain…Because as of today, if someone lost their job, then the lives of those who depend on them collapse. And also, their lives collapse, because you never know when else you'll get a job. So there has to be something to protect them from some of those things."*

The precarious nature of direct care work impacted immigrant careworkers uniquely. Time was seen as a function of how much they could earn, leading workers to live a hurried existence going from one job to another. Respondents felt the weight of being the sole breadwinner of their families and the burdens of many people depending on them.

Future

When asked about their future plans, overwhelmingly respondents desired to continue helping others in different capacities. The majority of respondents wanted to get further education or training to advance in their health care careers, most commonly as a nurse but also as a doctor, counselor, or simply continuing to work in elder care. "*Do I have plans? Of course you have plans. (laughter). Of course you should have plans for your future…I want to do like counseling. I would love to help mostly the women, women with their kids. I would love to counsel them and how to bring up their kids."* Though workers were eager for more financial security in their careers, they did not want to stop

being a caregiver necessarily, "*even if I'm in nursing school, I don't know if I'm going to leave those people (elderly clients). I can help, I'm still going to help people.*" For older workers nearing retirement, they were financially unprepared and this made them feel ill at ease but what was striking was their desire to continue to help others through volunteering reflecting a deep commitment to continue caring. Only one respondent discussed leaving caregiving entirely by pursuing her MBA but she did not express discontent with the field but rather thought business had more career opportunities. Six of the respondents desired to split their time in their country of origin or move back entirely when they retire. For the majority of respondents, their futures firmly rested in America with a strong desire to continue helping others. Overall it was clear that respondents held a deep commitment to helping others through their different stages of their career.

Respondents described having a strong desire for more out of their life but many found circumstances too challenging to pursue opportunities and expressed disappointment with their lives.

> *I want to be somebody (tearing up, very emotional). Like I said, I want to do the RN thing but I don't know if I could swing it. Like . . . the time to study and all that, work and my daughter's situation. I really have the desire to but can you do it? (laughter) I know people that have done it and failed and that scares me…Yeah because the way I have the passion and desire for it, I should have been somebody by now. (pause) I should have. . . but that holds me back.*

The future was an elusive goal that motivated immigrant homecare workers to leave their countries of origin in search of a better life but as the average respondent had been

working in homecare for an average of seven years, for some it did not appear to be the stepping stone they hoped. Though many felt they should have done more with their time, they still found great pride in their abilities as a good caregiver and the financial independence they were able to find.

Between Group Differences

What are the differences in perceptions and experiences of Caribbean and African home health workers?

The primary group difference between African and Caribbean respondents was their tendency to focus the conversation extensively on two distinct aspects of homecare work. Both groups experienced caring attachments with clients and described extensive discrimination but there was a clear difference between the groups. Differences were evaluated both on the frequency counts of themes mentioned and on the intensity of descriptions of experiences. Africans spoke more often and more extensively about the attachment they experienced to clients, *"It's like, for every client I work for, I, like, don't know if I feel sorry for them or I love them too much or I give them my best, but I just end up, just, taking them as family. Sometimes however nasty they are or not, but it's just how it is."* While Caribbeans spoke more often and extensively about the toll of abuse on them. A Haitian worker attributed her health problems to the stress she experienced while working at a nursing home, *"because I was -- this thing was so emotional, and then I end up getting high blood pressure, and then I ended up doing -- I wound up getting diabetes. Because it was so emotional, because that was the first time in my life I experienced this."*

African and Caribbean respondents also differed on the topic of kinship. Africans spoke more often (216 counts) about their families and had detailed descriptions of families as compared to Caribbeans (129 counts). Africans discussed their families back in their home countries extensively, often relating back their current caregiving knowledge back to that period. They also spoke about their families here in the U.S more often. Haitians on the other hand were reserved when speaking about their kinship networks.

Some of these different priorities and perspectives can be explained by the fact that the migration experiences of both groups were remarkably different. African respondents were older and had professional and educational achievements before immigrating. They generally arrived by receiving diversity visas or applied for refugee status and were granted with due process to stay in the country. However Caribbeans arrived when they were in their teens and arrived as undocumented immigrants. Their early migration histories were remarkably different for this reason. Perhaps this may explain why Africans spoke more frequently about their migration experiences as compared to Caribbeans.

What are the differences in perceptions and experiences by age cohorts of immigrant homecare workers?

The under 40 age group spoke extensively about their future aspirations. They were a very passionate group often saying they would "love" to achieve different goals. Many in this age group were pursuing higher education for advanced degrees in healthcare. Those 41-50 did not reach data saturation for this theme. Their answers were brief and not well thought out perhaps because they were not thinking of going back to

school or changing careers and they were not close to retirement and did not have plans as of yet, *"I don't know. The other plan I have when I retire -- 65 -- I'm waiting for 16 more years to come. And so, by 65, you know, I'm not going to work again."*

The under 40 age group spoke more often (113 count) and extensively about their relationships with clients as compared to age 41-50 (47 count) and over 51 group (106 count). Though other age groups did reach saturation on this theme, however, the under 40 group tended to focus the majority of their discussions on relationships and talked about their clients with exuberance, *"oh, wow! It's wonderful (smiles)! It's wonderful. Knock on wood, I have been so blessed."*

What are the differences in perceptions and experiences by years of experience and level of education of immigrant homecare workers?

No discernable differences were found based on levels of education or years of experience due to small sample size in groups or sample sizes varied too greatly for adequate comparisons.

Interpersonal and Organizational Strengths and Barriers to Providing Care

What are the interpersonal and organizational strengths and barriers to providing care?

Interpersonal

Strengths: Respect the Elderly; Extended Family Experience; Reciprocity

Barriers: Discrimination

Strengths

Interpersonal strengths that assisted or supported a caring relationship between the client and worker pertained to workers' values and previous experiences in caregiving, respect of the elderly and extended family experiences. These themes were mentioned previously in this chapter. Respondents commonly attributed their motivation to provide good care because they respected the elderly and believed that treating elderly persons with dignity and respect was a deeply engrained value for them. Additionally, their previous extended family caregiving experiences shaped their positive perceptions of caring and influenced their behaviors in their direct care jobs.

Reciprocity was often mentioned as an important element in developing a caring relationship developed between the worker and client. Part of developing a caring relationship involved openness by clients to receive the workers' efforts to connect, without this homecare worker knew that a close relationship would not be possible with some. *"If you cannot connect with the client, you can't give them quality care. You can't have a close association with them. So first of all, you have to make the client to connect with you. You have to make them like you. Love you."* Connections between the worker and client involved dual effort on making attempts to relate to one another. Respondents described how difficult the job could become if they did not like one another one respondent described that *"you don't want to go in there and be in a position that you don't like this person, but it's because you're being paid; that's why you're there. I want to go there and be able to give them hundred percent. Yes, with no limitations, without holding back. Yes, so yeah, it's very important for me to go and, if, if I have someone on a daily basis, we must be really, be on good terms."*

Personal Barriers

The greatest barrier to establishing a caring relationship was the discrimination that homecare workers experienced. Discrimination came from clients and their families on a frequent basis. In particular the initial meeting was a particularly trying time as clients would not open the door for the worker or call the agency and request for a white aide on their first meeting. During this sensitive time of initial impression, many aides used a variety of strategies to deal with this by gently educating clients such as *"we are all God's children"* or *"you can try me out and see if you like me before deciding."* Other times aides would use humor to bring up differences about culture, accents, and color of their skin to put the clients at ease. Aides described that clients often needed time to get used to them and most of these discriminatory behaviors would subside.

But in some cases the abuse was so persistent that aides asked themselves what was more important "*paycheck or dignity*." Aides described clients not allowing them to sit or use the bathroom, share meals and repeatedly degrading them and yelling at them like children. "*And oh, they even don't want to look at you. They'll tell you, you have an accent and I don't understand you. "What are you saying? Do you speak English? What language is that?" And stuff like that. But what can you do? You have to work, so."* These extreme cases took a toll on aides where they felt dehumanized and traumatized, "*why would you allow somebody to come to your house and take care of you if you do not want them to touch anything of yours? Then why do you allow them to touch you, to help you out? I thought about it and said, I can't -- this is not about a paycheck anymore. It's about my well- being and me going crazy, you know. It's... I don't love my job anymore.*" In a particularly emotional interview of a Haitian aide, age

33, she relayed a painful memory of a dementia client that had violent emotional swings that she found particularly difficult when she was being racist, "*and one day -- the last time, I said, OK, I'm not going to work with her is because she called me black. She said, "You will never be nothing. You are nothing. You're going to stay -- you're going to do what you're doing now. You will never be up. You will stay a home health aide and clean shit."* Unfortunately such cruel encounters were not a rarity and respondents frequently experienced extreme racism.

When asked why they stayed, they often said that they wanted to give clients a chance, clients were in need, or they pitied them. In some cases, aides informed their agencies of abuse but felt agencies could not do much to address the problem besides get them off the case and place another aide in the same home. Others felt fearful of telling agencies as they needed a job and they assumed this might happen again with the next client. Ultimately it became about how much the aide could endure and what was more pressing at that time, their paycheck or their sanity.

Organizational Barriers to Caregiving

Barriers

Organizational barriers to providing care pertain to the homecare agency practices or procedures that dissuade homecare workers from developing a close relationship with clients. In general, respondents perceived homecare agencies to have procedures to limit personal relationships forming and remain strictly professional. Respondents perceived the homecare industry focused on their bottom line as a business with less emphasis on the well-being of the client or worker.

Though all agencies had strict policies against doing unpaid labor by staying overtime, coming on days off, or doing tasks that are not part of their job descriptions, 74% of the respondents regularly helped their clients without the knowledge of their agencies. *"Even though I'm not supposed. I say, you know, that's my not my job but I'm going to do it for you today, OK. Or if it's something important. The person doesn't have anybody, you know, I'll just do it."* When asked why they go above and beyond their job descriptions and go against agency policy, respondents described the caring relationship motivated them to do unpaid favors for clients, *"I think it's because of the relationship... I stop seeing them as the client and begin seeing them as my friend or family. And the culture where I come from, we respect the elderly, plain and simple. We respect them, we take care of them. You don't even need to be paid for it."* Though respondents were aware that they could get in trouble with their agencies, respondents ultimately defied organizational protocols of remaining strictly professional with clients. *"Yeah, I do a lot. A lot. (pause) Sometimes they'll (clients) even call me on my day off. If I have to go, I will. I don't care (about agency policy). (pause) I'm in the field of helping people, not . . . and it doesn't matter if it's my client or not. If somebody needs me and I could do it, I'd do it. I don't care."* Ultimately workers felt a responsibility to clients that transcended their job descriptions and the expectations of their homecare agencies.

This sense of responsibility to clients was also challenged regularly when homecare agency expectations contrasted with client preferences for care. Both the homecare agencies and elderly person's family had expectations on what occurs within the home, at times in contrast to the preferences of the client or workers' best judgment.

Homecare workers described the conflict when agency expectations conflicted with the client's needs or expectations.

> *When the agency says oh, you're not supposed to do this for the client…then when the client says it is the opposite thing. The client says I love this, I love that. And then now, you make my work very hard…I have to do what the agency asks me to do, I have to do what the client asks me to do. And then you like, you're caught in the middle. It's like caught in the middle. You're -- the work is getting harder.*

Respondents described confusion when homecare agency mandates are in direct contrast to client's preferences. Ultimately workers' expressed their main priority was the client's preferences and what they thought was best for the care of the client. Another respondent described how some of the expectations of homecare agencies reflected a standardized model of care for all clients that did not account for the individual preferences.

> *But the company comes with one (way to do it) for everybody, you know? -- so it's really hard for you as the caregiver, for me as the caregiver, to do that… These are humans, you have to treat them like human. Like I -- like I do my job with them, I treat them like humans, and most time, it's not -- the company's not always right, most times, you know? They're not always right. So they (agency) listen to you as a caregiver and they get it right. And company's always growing when they listen to caregivers." (Nigerian, 32)*

This respondent made a strong case about the importance of specialized care that only she is able to judge as she is the one directly interacting with the client. The lack of worker

recognition in the caregiving process was notable as the care plan for homecare services was primarily shaped by agencies and clients' families.

Homecare workers also described the persistent difficulties with family members' expectations and what families thought was best for client care. In one particularly disturbing encounter with a client that was terminally ill, the respondent described the excruciating experience of watching her client pass away without medical intervention despite her best judgment. "*She's very sick. I'm confused. Should I call 911? Should I --I'm confused. My job tells me to call 911. The family's telling me don't call 911. It was terrible.*" Often feeling stuck between families and clients was a severe challenge for workers. Respondents described having to manage family expectations as part of the job. Kimberly a seasoned homecare worker of 21 years found that she could easily handle most things about her job except the difficulties with family members.

> *She's jealous of me helping the husband, you know? So, if you're helping him getting out of the bed, she's there…Yes, it is complicated. Even the family, the son, the daughter, they can't get along, but you're in the middle of it. So, we focus on him, that I know we're coming to work for him, we do what we have to do for him. But you know, sometimes she make it very, very difficult. She try to hit us.*

For Kimberly the most difficult aspect of the job was managing the family relationships surrounding the client. Being caught in the middle between clients' needs and the protocol set by the agency or family was a challenge to establishing caring relationships with clients.

The greatest organizational barrier to developing a caring relationship for workers was the discrimination they suffered from supervisors. It was perceived that they were discriminated against for their race, as immigrants, and due to the low status of direct care jobs. Abuse and discrimination by supervisors had the most detrimental effect on direct care workers' job satisfaction and sense of well-being.

> *At the hospital…you are so invisible to them. The doctors, the nurses, they just pass you by. I really think some of them don't even know who I am…Nobody says good morning. Nobody says thank you, nobody says are you OK…Like one nurse told one aide, 'You are the bottom of the step so that you need to be stepped on.' You know what? It's so unprofessional and so rude.*

Workers were able to exercise patience and empathy towards clients when they discriminated against them often attributing this to declining mental abilities or the consequences of living with persistent pain. However they were unable to comprehend why social workers and nursing supervisors looked down on them and failed to acknowledge the valuable contribution they made.

> *And it also feels like the (homecare) agencies themselves, they don't treat us well. For me, the way I see it is, to them, it's a business. But it's funny because some of the people who are managing these agencies are social workers and you would think they should care about the human race…And they know that if I walked up and said, "I don't want to do this job," tomorrow, they'll have another immigrant coming to them and saying, "I need a job." So they end up just treating us anyhow.*

The mistreatment they received by their supervisors motivated workers to leave the profession entirely. Several noted this was the impetus to get further education in order to obtain a nursing job. "*They judge you….That's why now, these days, it's very difficult now to find a nursing assistant, because they don't want to work in the nursing homes, first of all, and then most of (aides), they go to school…Because they (nurses) put…them so low, they make them feel like a low self-esteem and everything, you know?"* The continual discrimination they experienced was a detriment to their sense of well-being and feelings of satisfaction as a caregiver.

Summary

Findings indicate that respondents have a well-developed understanding of their caregiving identity that has formed overtime. Immigrant homecare workers' notions of care have been strongly shaped by their "past" with extended family experiences of caregiving and adapting cultural values to "respect the elderly." Homecare work is multifaceted and the "present" theme highlights the confusing emotions workers hold simultaneously experiencing "pride and shame" as well as the hurried lives they live under "time is money." Workers also describe their motivations to provide a "high standard of care" for clients that goes above and beyond their paid formal responsibilities. Supports for developing a caring relationship with clients include respecting the elderly, experience with family caregiving, and reciprocity of care by clients. Findings also illustrate that pervasive discrimination from clients and homecare agencies as the primary barrier to developing caring relationships. Additional organizational procedures and protocols discouraging personal interactions and limiting personalized care have been found. Lastly group differences between African and Caribbeans, and age cohorts

illustrate the variance in experiences between groups. The next chapter will offer

discussion of these findings as well as future research and implications of this study.

Chapter V. Discussion

Overview

The commodification of care and the devaluation of carework have resulted in educated women in richer countries like the U.S. and Europe "outsourcing" their care responsibilities to immigrant women from developing countries. The rapid growth of aging baby boomers in need of long term care is driving a global demand for immigrant direct care workers. Yet little research or policy attention has focused on this vast growing immigrant labor force in the elder care sector.

Though previous research has focused on highly-skilled healthcare immigrant workforce, this study focused on low-wage homecare workers. The intersection of race, class, and gender is a ripe area of research for both macro policy investigation but also the micro implications of providing care as an immigrant woman of color. The migration of female direct care workers is directly impacted by immigration policies of the receiving country and colonial histories with the developing world. Changes to U.S. immigration resulted in the granting of diversity visas to well-educated Sub-Saharan African immigrants, who arrived within the last two decades but faced substantial barriers for new immigrants that resulted in a downward mobility for this group. The majority of Caribbeans arrived in the 1980s escaping political turmoil or poverty and arrived as undocumented immigrants or came under family re-unification auspices. Both immigrant groups are the primary workforce for homecare in the Massachusetts area.

This chapter focuses on a) interpretation of findings; b) limitations of the study; c) recommendations for future research, policy, and practice d) conclusions for the study.

Interpretation of Findings

African and Caribbean women from developing countries migrated to the U.S. and took on care positions in hopes to have a better life than the one they left behind. Positions in home health were readily accessible for newly arrived immigrants, with Caribbean and African communities helping them find care positions. Decades later many of these immigrants remain in homecare work though they did not have intentions in working in elder care when first arrived. Overall, immigrant homecare workers in this study portrayed complex dynamics as paid caregivers that has implications in their work and personal life.

At the heart of homecare is the compassionate and caring relationships formed between worker and elderly client. Difficult to observe or measure, emotional care has been largely absent in previous research. This study focuses on the caregiving experiences of immigrant homecare workers and its centrality to quality care and worker identification as a caregiver. The study is a holistic account of participants' paid caregiving experiences and not limited to homecare settings or current homecare agency employment.

Often homecare programs follow institutional health care models by encouraging workers to remain professionally distant. Yet homecare is dynamically a different work setting that involves intimate care that is largely solitary between the worker and client, and thus involves a strong expectation to provide family-like care. Within this continuum, homecare workers are asked to behave as healthcare professionals but also provide care like a daughter would to her own mother or father. Confusion exists because the central core of elder care provision is the caring relationship and it seems incomprehensible to

ask workers to express such personal and intimate emotions. Homecare agencies, workers, and policy makers alike express conflicting views on what are the dynamics of paid emotional care and how much can be mandated.

During employment within the private homes of clients, a complicated picture emerges when the notion of "care" is transformed into a commodity. When a paid caregiver provides personal care or housekeeping services, this alone is a confusing experience for dependent elderly. But the provision of emotional care simply does not easily fit into conceptions of paid employment. Homecare is an uncertain workplace where boundaries between the formal aspects of the job and the informal aspects of the job were blurred (Lindahl et al., 2011). Workers and clients struggled with "care" as a commodity and find ways to relate to one another that surpasses a strictly professional relationship to reflect more personal relationship models. Workers placed great emphasis on establishing a good relationship with clients, often drawing from their previous caregiving experiences and their values to care for the elderly. While clients also opened up and shared their lives with workers. Guided conceptually by emotional labor theory, it was found that home health workers performed emotional labor "deeply" and professionally identified with being a direct care worker much in the same way as other health care professionals (Froggett & Richards, 2002; Henderson, 2001; Larson & Yao, 2005; McCreight, 2005).

Findings indicate that immigrant homecare workers overtime develop a professional identify as a caregiver that reflects their deep moral commitment to provide quality care that goes beyond their job duties. Their identification as a caregiver was illustrated in a sequential presentation of themes related to their past (before becoming a

paid caregiver), present (current paid caregiver experiences), and future (aspirations in carework).

Immigrant homecare workers' perceptions of caregiving were heavily influenced by their prior family experiences and culture of origin. Workers viewed elders as part of the community and described a sense of responsibility for vulnerable persons in the community. Respecting the elder was described as a central ethos as a caregiver, *"I mean, without respect, nobody can trust you. And respect is the first thing -- should I say first priority?"* Respect and caring were common themes mentioned when workers relayed stories of family care for loved ones and those in the community. Previous studies have not explored cultural influences on caregiving behaviors of direct care workers but rather focused on racial stereotypes that employers or care recipients perpetuated that certain nationalities promote favorable behaviors such as being docile, caring or nurturing (Bourgeault et al., 2010; Yeates, 2005). In the desire to not stereotype cultural groups, at times it appears research has undervalued the impact of culture on behavior and values.

Presently, the "pride and shame" theme illustrates the confusion direct care workers experience paid employment as a caregiver. Their pride in their work is related strongly to their own family experiences in caregiving and their cultural heritage. Similar to Morgan's (2005) findings, respondents' described aspects of the work positively, despite significant barriers because of their gender socialization and cultural values. However workers also simultaneously felt "low" and expressed great shame because of the treatment of others, *"when clients don't acknowledge you're doing a good job… and you have to do every crappy thing, that really puts you low, puts you down."* Of

particular concern is the severity of discrimination that immigrant homecare workers faced as a byproduct of their low status as homecare workers as it intersects with their gender, race, and immigrant status. Previous studies have indicated pervasive discrimination towards immigrant direct care workers at rates higher than for native born workers (Berdes & Eckert, 2001) and in particular higher rates of discrimination were directed towards African workers as compared to other immigrant groups (Doyle, M., Timonen, V., 2009).   Many moral implications exist when employing vulnerable immigrants to provide care to an equally vulnerable client group with little training or worker protection for the discrimination they are likely to face.

Caribbean and Africans' quick adoption of caregiving jobs is remarkable and relate significantly to their own gendered imagery of a being good caregiver. Transferring their own care responsibilities from their loved ones to that of their clients was not uncommon. For respondents who did not have families in the U.S. or felt socially isolated, homecare workers sublimated their loneliness with deep attachments to clients similar to previous studies on nannies (Ehrenreich & Hochschild, 2004). Caregiving was a fundamental part of many immigrant women's lives as they talked about their role as mothers, daughters, or aunts and along the continuum was their role as a paid homecare worker. The primary addition to previous literature is this study's exploration of caregiver identity formation over time.

Respondents expressed their deep commitment to provide good care that went beyond the "call of duty" (Neysmith,S. M. & Aronson, J., 1996). Four sub-themes captured respondents' commitment to provide a "high standard of care": a) specialized skills b) karma c) friend or family d) caring fills the void. Immigrant homecare workers

viewed empathy and patience as the most essential "specialized skill" in providing good

care to clients. Their focus on good care extended beyond the work related tasks but

involved the social aspects of relating to clients. This in particular was an illuminating

finding as previous policy focus on skills training such as using a bed lift or dementia

training and an absence on emotional skills. Perceptions of workers that emotional care

is indeed a valuable skill set as a homecare provider speaks to the importance yet

neglected contribution of emotional care with important implications in practice and

future policy initiatives.

Significant motivators to provide good care to clients was related to themes

"karma" and "caring fills a void." Motivated by strong religious orientations that

unkindness or good acts will revisit them or their families, respondents perceived that a

higher power watched over their interactions with clients. This particular aspect of the

caregiving experience was not described in previous studies. Caring for one another had

positive outcomes for workers and clients that felt lonely and isolated in their current

circumstance. Literature on migrant caregivers have echoed similar results detailing the

tremendous loss that occurs for women separated from loved ones, in particular those

separated from their children (Ayalon, L., Shiovitz-Ezra, S., 2010; Bao, 2008; Chang,

2000).   Similarly immigrant homecare workers felt an intimate and personal bond

formed with clients that went beyond a professional relationship.

The vast majority of immigrant homecare workers viewed their clients as "friends

or family" similar to previous studies with native born and foreign born workers (Piercy,

2000; Porat, I., Iecovich, E., 2010). Immigrant homecare workers rarely referred to their

clients as babies or children unlike previous findings that older native born workers

described Alzheimer's patients as babies (Berdes & Eckert, 2001). Immigrant homecare workers' cultural perception that the elderly are to be respected unconditionally shaped their view of clients as sisters, friends, or parents.

Contrasting the positive relational outcomes of homecare work is the precarious work environment, captured by the theme "time is money." Combination of low wages, unpredictable weekly work hours, lack of benefits, and workers' wages supporting many dependents including their children and family abroad, respondents struggled to survive in Massachusetts. Descriptions of workers living paycheck to paycheck or working well over sixty hours a week were common. Seventy percent of the respondents of the study indicated working in uncertain work conditions by being under-employed or over-employed chronically. For those who were underemployed, they worried if they were going to be able to pay rent or eat that month. Several respondents were deeply moved to be receiving the $25 grocery store gift certificate for participation in this study. Those over employed found themselves running between one direct care job to another while balancing with other responsibilities such as family or school, *"time is money. When you sit at home, you're not getting money, so you use the time to sit at home to go to work…You gotta work, work, work."* To meet with the researcher for participation in this study was difficult and it was common for respondents to cancel or not attend scheduled interviews largely in part of their unstable work schedule. Fifty-seven percent of respondents were sole breadwinners in their family and the strain to provide for their families and extended relatives struggling abroad placed great pressure on direct care workers. Despite such unstable working conditions, the vast majority of respondents

desired to continue in caregiving reflecting a professional identification as a caregiver that transcended it being strictly about a paycheck.

As immigrants seeking a better life in this country, respondents described that after many years of pursuing the American dream, some dreams were actualized and others would probably not happen for them. They were a very hopeful group actively pursuing higher education in the midst of rotating work schedules, some with young children at home. Though workers had the opportunity to pursue any number of degrees or career vocations, they desired to continue in health care and continue helping others. For workers nearing retirement, they also talked about helping others through volunteering. Overwhelmingly, respondents portrayed themselves as a caregiver and though they may advance in their careers, their commitment was to continue helping. Their professional identification as a caregiver reflects that respondents had taken on emotional labor of this job sincerely and were "deep acting."

Investigation into the interpersonal supports and barriers of the caregiving relationship is useful to help promote positive relationships in the future. The interpersonal supports of the caregiving relationship were related to respecting the elderly, previous extended family experiences and reciprocity by the client. Besides workers' personal motivation to care, it appears the elderly client also plays a significant role in opening up avenues for relationship building. Though the client in one sense is dependent on the worker, they also hold great power in the relationship to build stronger relationships or be harmful to the worker.

The greatest interpersonal barrier to developing a caring relationship was the abusive and discriminatory behaviors by the client. Immigrant homecare workers regularly experienced subtle forms of discrimination against their skin color, immigrant status, and unfavorable view of being a homecare worker. But at times the abuse was so pervasive; workers asked themselves if they could endure the humiliation, it is my *"dignity or paycheck."* When immigrant homecare workers discussed this aspect of their homecare experience, their faces displayed sadness, humiliation, anger or fatigue. Discrimination could be subtle, such as making comments about accents or making assumptions of life in Africa. However clients could also be abusive by hitting, yelling, isolating the worker to parts of the home, refusing to allow her to sit, use the bathroom, or eat in the home. Discrimination and abuse took an obvious toll on workers and they had to use a variety of coping skills to deal with discrimination such as using empathy, humor to disarm clients, and conveying competency in their jobs.

An area of important policy and program implications is the organizational barriers to developing a caring relationship. It was found that respondents experienced confusion during instances that homecare agencies overemphasized professionalism when the relationship was perceived as the core of quality care. Homecare workers described the professional expectations of them to provide efficient care and complete work duties with less emphasis on social relationships or genuine emotional displays towards clients. Similarly to previous research, workers did not feel agencies gave them authority to directly address discrimination or abuse but rather expected them to react in a distant and removed manner (Lopez, 2006b). Workers described feeling "stuck in the middle" between organizational procedures and the clients' preferences for care.

Personalized care is a hallmark of quality care of clients, yet homecare agencies devalued the competency of homecare workers to judge best care practices and required a standardized care procedure for most clients.

Additionally, though homecare agencies all prohibited doing unpaid labor for clients, the majority (74%) of immigrant homecare aides regularly helped clients beyond the formal duties of their jobs. Staying after their shifts to talk was common, as well as doing tasks unrelated to care but helping with home maintenance or buying extra personal items like soap or cereal without being reimbursed. These efforts indicate that despite organizational procedures against unpaid work for clients, immigrant homecare workers were exercising their own agency to genuinely show compassion to vulnerable clients (Bolton, 2005; Foner, 1994). Despite organizational barriers to care, immigrant homecare workers strived to provide a "high quality of care," that was aligned with their own moral standards. Respondents genuinely cared for their clients and performed emotional labor "deeply" and identified with their work persona as a direct care worker in this case (Lopez, 2006a).

The greatest organizational barrier to care was the pervasive discrimination that workers faced in the workplace. In particular workers described incidents of workplace disrespect and devaluation of their contribution to health care that ultimately took an emotional toll on workers' satisfaction with their job. Direct care workers expressed feelings of shame and fatigue when they were mistreated by their nursing and social work supervisors. As homecare workers have less contact with their homecare agencies, nursing home and hospital settings stood out as environments that were difficult for direct care workers, *because you're a nursing assistant, they are nurses ...they treat you like*

you're a moron because you can't do better than that, they're going to treat you bad." A consequence of workplace discrimination was a desire for nursing assistants to gain more education and become nurses themselves in hopes that they may be fairly recognized and compensated for their care efforts. In previous studies, it was found that 85% of foreign born nurses' aides experienced racism on the job by clients, families, or other staff higher than native born nurses' aides (Berdes & Eckert, 2001). Discrimination from the client or organization consistently ranked as the most detrimental barrier to having caring relationships with clients.

Though homecare workers regularly suffered egregious discrimination from clients and homecare agencies, overwhelmingly workers valued their caregiving roles. Despite homecare agencies' devaluation of the "caring" aspect of the job and instruction to remain professional, homecare workers felt a moral commitment to clients that often went beyond the "call of duty" by performing unpaid favors for clients (Neysmith, S. M. & Aronson, J., 1996). Morgan (2005) described how gendered imagery of women's role, centered on nurturing and caring for others, shaped direct care workers' perceptions of job quality and the meanings they attribute to the job. Similarly African and Caribbean homecare workers' previous experiences of gender socialization, cultural expectations, and religious contexts shaped their perceptions of the job so that they found intrinsic value even if the work involved low compensation and status.

Interpretation of Secondary Findings

A qualitative analysis of group differences was conducted by noting saturation of a theme, frequency counts of themes, and richness of the descriptions of themes. Measurement of differences between groups did not occur. The primary difference

between African and Caribbean groups was the focus of their conversation on different aspects of the caregiving experience. Africans had a tendency to concentrate the majority of the conversation on relationships with clients and their kinship networks here and abroad. Similar to findings in a previous study on African direct care workers, this group valued caregiving relationships more than other immigrant groups, despite experiencing higher levels of discrimination at the workplace (Doyle, M., Timonen, V., 2009). Caribbeans focused on the challenges of the job, and in particular the discrimination they have faced. Caribbeans also spoke less often about their kinship networks.

Some of these differences are most likely explained by the different migration experiences between groups. African immigrants are more likely to be educated with prior professional experiences which may account for Africans ability to cope or manage discrimination differently as to allow for better caregiving experiences. The majority of Africans have immigrated in the last fifteen years and family ties are likely to be stronger. The majority of Caribbeans immigrated in the 1980s and their kinship networks have vastly changed over time. Caribbeans tended to arrive at a younger age without higher degrees or career experiences which may shape their ability to cope with discrimination and other challenging issues in homecare.

Differences between age cohorts are primarily related to future aspirations for different generations of workers. Those under 40 were understandably goal driven to pursue higher education degrees and advance in health care jobs. Those in the 41-50 groups did not think extensively about the future and this group in particular did not reach saturation on this theme. Perhaps this age group is unlikely to return for more schooling but retirement is still fifteen to twenty years away, so they may feel it too early

to focus on retirement goals. Though all age groups reached saturation on caregiving relationships, the under 40 group was far more likely to focus the conversation on this topic as compared to the other groups. They expressed greater enjoyment and fondness over their clients as compared to other age groups.

Other group differences between levels of education and years of experience were difficult to ascertain as groups had few cases to compare sufficiently. Future research with greater number of cases for levels of education and years of experience would add to this study.

Implications

Future Research

Based on the findings of this study, the following suggestions are provided for future research. Qualitative description findings from this study suggest the need for theory development on caregiver identity formation over time. To further advance this theory, future research, using a grounded theory approach, would aid in developing a working hypothesis for future research.

A mixed methods study, utilizing the qualitative findings of this study as well as quantitative measures from the Home Health Survey, would better assess the impact of vulnerability and discrimination of immigrant homecare workers on worker satisfaction and patient outcomes. In particular the Home Health Survey is the first to capture immigrant homecare workers experiences and is a valuable resource to obtain greater data using a larger sample.

An intervention project might be developed, driven by the qualitative findings of the study, to better assist immigrant direct care staff experiencing pervasive discrimination on the job. An immigrant direct care workforce would benefit from additional supports with challenges related to the job. Objectives would be to support diverse direct care workers with multicultural challenges and discrimination but also provide coping skills to effectively communicate with clients and supervisors.

The largest numbers of immigrant direct care workers are from Mexico and the Philippines. Further research should evaluate the experiences of these two large cohorts. Also, larger samples of immigrant groups are needed to evaluate between group differences. Additionally though respondents in this study were asked about their future career aspirations, it would be beneficial to conduct a longitudinal study on the career aspirations and outcomes of immigrant home health workers.

Lastly as the research on home health workers and in particular a multicultural workforce advances, it would be important to understand and evaluate the competencies involved in direct care work. In particular the relational aspects of caring are clearly not understood by many long term care settings and are not identified as valuable or considered as measurable standards for recognition or pay raises. Although relationships are clearly a major altruistic reward of the job and clients receive better care, emotional care is often taken for granted. This area of research would be greatly enhanced by further investigation of competencies related to relationship building.

Practice

The greatest challenge in recruitment and retention of workers into the home health field is the instability and low wages associated with these jobs. Though many workers prefer to work one on one in the home health field, the lack of job security leads them to work in acute or institutional settings. With many in the baby boomer generation's preference to receive care at home, and a greater emphasis of the Affordable Care Act to provide community based care, it would be advantageous to transition hourly home health jobs into full time employment opportunities.

An additional challenge to home care work is the devaluation of the profession as un-skilled labor. Professionalization of the field would increase quality care and offer greater opportunities for the workforce. Home care workers with advancement opportunities into nursing would be attractive to many of the highly educated immigrants increasingly taking on this work. Also, advancing their contribution in care coordination and medical monitoring would elevate the role of direct care workers and possibly add to greater compensation of the work.

Lastly, discrimination is one of the most pervasive challenges in home care work. It would be beneficial to offer worker training on communication with clients and supervisors. Recognizing cultural misunderstandings, communication barriers, and prejudice or bias and knowing how to utilize effective communication tools to manage these unpleasant encounters, would aid workers' job satisfaction greatly.

Policy

As this study was being completed, one of the greatest policy advances in the field occurred with the passing of the Fair Labor Standard Act of 2013. Direct care workers will now receive minimum wage and qualify for overtime compensation. Though this was a large victory for the field, greater labor protections are needed such as paid sick days and family leave. Those charged with the care of frail and dependent elderly, lack simple protections for when they or their family members become ill. Fortunately, the Affordable Care Act will require homecare agencies with fifty or more employees, to offer affordable health insurance to full time workers. However, as many homecare workers are chronically under-employed, many will still be left without health insurance.

Several demonstration projects and training programs are taking place around the country elevating the role of direct care workers. Increased demand for consumer direction requires transitioning workers from institutional care models to home based care. Increased health care needs will be met within the community, requiring greater clinical training for home care workers who will be providing the day to day care of elderly persons. Additionally the Affordable Care Act is funding demonstration projects in several states on training of personal care attendants and home care aides, as well as creating advancement opportunities for direct care workers into nursing positions.

Though many of these policy initiatives are advancing direct care work, it is still anticipated that native born workers will not be willing to take on these jobs and it will largely fall to an immigrant labor force. Policy initiatives have not taken this into account and largely failed to incorporate immigrants into policy initiatives. Immigrant workers

face additional challenges and bring specific skill sets different than the native born population.

Lastly programs and policies have failed to recognize the importance of positive caregiving relationships and foster positive interactions between worker and client. Creation of programs begins with the most basic system of care, the micro relationship between a caregiver and elderly client. Emotional care has largely been taken for granted by homecare organizations and failed to be recognized as a valuable skill deserving of recognition and adequate compensation. Recently SCAN Foundation (2013), found that older adults' satisfaction with long term care services centers on the relationship with their direct care provider. The central core of provision of elder care services therefore, will need to be on fostering the caregiving relationship.

Limitations

The primary limitation of this study is related to the sampling of respondents that are considered "good workers." Homecare agencies referred workers to the project and they are likely to be biased towards encouraging workers they liked to participate in the study. Agencies most likely referred workers with good work histories and exhibited satisfaction in their jobs. Respondents were able to describe a more nuanced view of their work including challenges and rewards but they were not a group that was disillusioned by their work and likely to disengage from clients. Within this study, undocumented workers were excluded due to the additional layers of immigration laws and exploitation of undocumented workers. Though an earlier study estimated that only 21% of immigrant direct care workers are undocumented (Martin et al., 2009), private homecare workers are likely to have higher prevalence of undocumented workers. It was common

for Haitian respondents to find private homecare positions before their legalization of work status. It is estimated that 11.5 million unauthorized immigrants reside in the U.S., primarily in California, Texas, Florida, and New York (DHS Office of Immigration Statistics, 2011). Further research on homecare workers would be greatly enhanced through the inclusion of undocumented workers.

English was a second language for some of the respondents and it is anticipated that at times descriptive validity may have been impacted. Efforts were made to include only respondents with sufficient English proficiency into the study by assessing language abilities over the phone prior to meeting for the interview. In certain cases, potential respondents were excluded for the study if they were unable to communicate adequately with the researcher. This was a rare occurrence, as most potential respondents had worked for a number of years in the home health industry and presented a proficient grasp of the language.

Lastly, group differences were difficult to observe due to the small numbers of participants in each group. It would be beneficial to have a greater number of respondents in each category to better differentiate experiences by country of origin, education, and years of experience. The small sample size makes it difficult to make generalizations to the population as a whole. Also, it was a limitation of the study to group vastly different countries into large regions of Africa or Caribbean for comparison. Future studies may elect to do a comparative study between countries rather than regions to get a better understanding of differences between cultural groups. For instance, differences between Haitian immigrants and Jamaican immigrants offer a strong basis of comparison for between-group differences.

Conclusion

The growing numbers of immigrant homecare workers in the long term care system reflects a growing "pull" of migrant caregivers from developing countries to fulfill the elder care needs in the U.S. Increasing numbers of baby boomers will need elder care and their strong preference to receive services within the home will also increase this demand. Findings in this study describe the richness of caring relationships between homecare workers and clients. However this study also illustrates the exploitation of immigrant caregivers that further exacerbates the inequality that low wage workers face and in particular impacting women and persons of color.

The vast gaps between the wealthy and poor are increasing with each passing year as the wealthiest group makes substantial gains and the poorest third are struggling to make a living. The lasting effects of the recession of 2007-2009 can still be felt by working class families struggling to come out of debt and have a decent standard of living. For immigrants, direct care work is a life source that allows them to be financially independent and pursue aspirations for advancement in health care jobs. But their lives reflect the dangers of low wages and overwork, struggling to support themselves and their families both here and abroad. Beyond the consequences to workers and their families it can be asked what the consequences are for society to exploit caregivers in this manner. Dodson (2009) brings up questions about the responsibility employers and society as a whole have towards low-wage workers and what they can do to support working class families. Her research on low wage workers and middle class managers gives a surprising look on the ways that groups practice economic disobedience to compassionately support the working poor. Within long term care research, concerns

about providing good care for the old and recruiting enough workers to fulfill this

demand have been well documented, however conversation about the ethical and humane

employment of the givers of care have not been adequately addressed (Nussbaum, 2002).

Future policy and program initiatives will need to address this ethical dilemma before the

successful recruitment and retention of workers will take place.

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Appendix A

Conceptual Model

THEORY

Nurses Migration (Redfoot & Houser, 2008)
   1) Demography factors and domestic worker shortages
   2) Growth of caregiving labor market
   3) Colonial history
   4) Aggressive international recruitment
 	
Individual Decisions to Migrate (Kingma, 2007)
   a) Pull factors of recipient country (financial incentives, recruitment, economic policy, trade agreements).
   b) Push factors of source country (poor pay, poor working conditions, occupational risk, and employment security).

RESEARCH QUESTIONS

| |
|---|
| 1) What are the migration experiences of immigration home health workers? |

INTERVIEW QUESTIONS

1) Push/pull factors 2) Stick/ stay factors 3) Recruitment 4) Challenges as immigrant worker 5) Kinship

THEORY

Carework
- For many, affective care is the most rewarding part of the job.
- Barriers to affective care
  a) devaluation by agency that emphasizes professional detachment
  b) interpersonal barriers including discrimination

Emotional Labor (Hochschild, 1983)

  a) Commodifying "care"
  b) Professional identify with the work—superficial or deep act
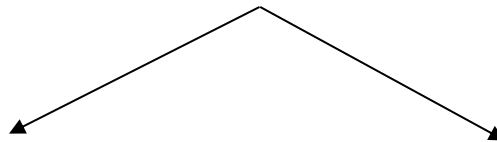
RESEARCH QUESTIONS

1) How do immigrant home health workers describe their caregiving relationships with clients?

2) Subquestion: What are the interpersonal and organizational strengths and barriers to providing care?
3) Subquestion: What are the differences in perceptions and experiences of Caribbean and African homecare workers?

INTERVIEW QUESTIONS

1) Descriptions of relationships
2) Feelings about client and job
3) Relationship impacts care

1) Motivations
2) Discrimination
3) Challenges
4) Agency expectations
5) What's important to you

Appendix B

First Iteration of Semi-Structured Interview Questions

These questions guided the interviews but not all questions were asked as respondents readily discussed many of these themes when simply asked an open ended question about their caregiving experience or migration history. They also brought up relevant issues for them not captured by this list.

    <u>Demographics</u>
1) Age
    Highest education obtained
    Marital status
    Number of children
    Country of origin
    Immigration date to the U.S.
    Languages spoken
    Years in Job and Types of Jobs
    <u>Migration History</u>
2) Tell me when and why you decided to leave your country?
3) Why did you come to MA? Were you in other states before? Why Boston?
4) What made you decide to stay in the U.S.? How long have they been here?
5) How did you find this job? What other jobs have they had? What kind of training did you receive for those jobs?
6) Past experience in carework before coming to this country?
7) Are there particular challenges at this job because you are an immigrant?
8) How is your life different here in the U.S.?
9) Do you still have family in the country of origin that you help? Describe the relationships?
10) How has working as a home health worker affected you and your family?
    <u>Work Setting</u>
11) Do you feel co-workers value what you do?
12) Describe your relationship with your supervisor and home health agency?
13) Do you ever feel like other people don't value what you do? Give examples?
    <u>Carework</u>
14) Describe the type and numbers of clients you have?
15) Describe the relationship you have with clients. Explain why?
16) What do you like about your relationships?
17) Describe the parts of your job that make you feel good.
18) What are the stressful parts of your job?

19) Have you had a hard time with a client? Any discrimination you've faced from the client or their families?

20) Are there instances that you haven't become close to a client? Why?

21) Do you ever feel like you pressured to do extra things for the client?

22) Is it ever difficult to have boundaries or say no to a client such as staying only for the amount of time you are paid, doing extra unpaid favors or even providing medical care?

Additional questions about the context of their experience

23) Tell me about a typical day for you.

24) How do you take care of yourself?

25) What's your day like when you're not at work? Are you able to meet your needs in health care, child care, transportation, bills?

26) What would you like other people to know about being a home health worker?

27) What would you like me to know about you?

28) What plans do you have for the future? (Education, switch jobs, return back to your home country).

I will explore initial answers more in depth by probing participants until their experiences are fully re-counted.

Could you give me an example?

What was that like?

Do you remember how you felt?

What were you thinking when that happened?

How did you handle that?

Appendix C

Final Iteration of Semi-Structured Interview Questions

<u>Demographics</u>

1) Age
   Highest education obtained
   Marital status
   Number of children
   Country of origin
   Immigration date
   Languages spoken
   Years as HHW
   <u>Carework</u>
2) Describe the relationship you have with clients. Does the kind of relationship you have impact the quality of care?
3) Karma-when you take care of someone, have you ever thought about will it be like when you are older?
4) Describe a difficult time with a client?
5) Have you experienced discrimination from the client or their families?
6) When clients are not motivated to get out of bed, take a bath, or in a bad mood; how do you interact with them?
7) Do you ever feel lonely here in America? Does taking care of the client help with that? Have you ever felt part of a client's family?
8) Have you ever become very sad when you lost a client?
9) Is it ever difficult to have boundaries or say no to a client?
10) Another HHW told me that a big part of the job is to pretend your feelings. Have you ever done the same?
11) Tell me a time you felt low being a HHW? Do you ever feel people don't respect what you do?
    <u>Migration History</u>
12) Anything going on in your country that made you decide to leave? Why did you decide to leave your country?
13) How did you find this job?
14) Past experience in carework before coming to this country?
15) Who do you miss? Do you still have family in the country of origin that you help?
16) What are your plans when you are older?
17) Another HHW told me time was money. Do you feel the same?
    <u>Work Setting</u>
18) What is important to your agency? What is important to you?
19) Do you work for multiple agencies? How many clients? Hours do you have?
20) Do you have enough hours to meet your financial needs?
21) How is your relationship with your supervisor?
    <u>Additional questions about the context of their experience</u>
22) Tell me about a typical day for you.
23) What would you like other people to know about being a home health worker?
24) What plans do you have for the future?

Appendix D

Long Term Care

Research Study

Boston College

Seeking female immigrant home health workers to participate in a research study on long term care. The study is looking at the _contribution_ of immigrant women caring for the elderly.

- Looking at the backgrounds of immigrant caregivers.
- Trying to understand what its like to be an immigrant caregiver.
- Also to hear your stories on rewarding or challenging experiences you've faced.

In recognition of your participation, a Stop & Shop gift card of $25 will be provided for each interview or focus group session you attend. Interviews will take place near your home or work during times convenient for you.

Boston College

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Appendix E

Boston College Consent Form

Boston College School of Social Work
Informed Consent for Participation as a Subject in Study of Immigrant Home
Health Workers
Investigator: Patricia Yu, LCSW, PhD Candidate

Adult Consent Form
Introduction
- You are being asked to be in a research study of immigrant home health workers' experiences working with the elderly and your immigration story. You were selected as a possible participant because of your work with elderly clients.

Purpose of Study:
- The two main purposes of this study are to find out more about your relationship with your clients and to discover your how you came to start working as a home health aide.

Description of the Study Procedures:
- If you agree to be in this study, we will begin an interview today which may last between 1 to 2 hours. Within a year's time, we may ask you for a second interview to expand on anything interesting you brought up today. Interviews will be recorded and your identifying information will not be on the audio file.
- If you are not selected for the **first or second interview**, we may also ask you to participate to be a focus group member. The discussion with ten or fewer home health workers will last 1 to 2 hours. Focus groups will be recorded and your identifying information will not be on the audio file.

Risks/Discomforts of Being in the Study:
- During this study, if you feel uncomfortable at any time talking about your immigration story or events that happened at your job, let me know and I will stop the interview and stop recording the session.
- I have a list of resources for you if you feel the need for counseling services.

Benefits of Being in the Study:
- We would like to recognize the contribution home health workers make to society taking care of the elderly.

- The primary benefit is for the chance to tell your story and share your experience about what it's like to form relationships with your clients.
- Also you'll help add to the knowledgebase on long term care of the elderly.
- But also help researchers understand the experiences of the worker.

Payments:
- You will receive a Stop & Shop gift card of $25 for each interview or focus group session you attend. You will receive this gift card even if the interview or focus group does not last two hours or you decide to stop participating in the study.

Costs:
- There is no cost to you to participate in this research study.

Confidentiality:
- Your participation in this study will be kept private. Your identifying information will not be written in anything that is written about this study. Also your home health agency will not be informed of anything you tell us today.
- **The only exception is if you tell me you have hurt yourself or someone else, I will have to share this information to the authorities.**
- All electronic information will be coded and secured using a password protected file. Digital audio recordings will be made and I will be the only person with access to them. I will erase files after the conclusion of the study but I will keep the transcriptions for a longer period of time.
- Access to the records will be limited to the researchers; however, please note that regulatory agencies, and the Institutional Review Board and internal Boston College auditors may review the research records.

Voluntary Participation/Withdrawal:
- Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University.
- You are free to withdraw at any time, for whatever reason.
- There is no penalty or loss of benefits for not taking part or for stopping your participation. You will still receive the gift card for your time.

Dismissal from the Study:
- The investigator may withdraw you from the study at any time for the following reasons: (1) withdrawal is in your best interests (e.g. side effects or distress have resulted, (2) you have failed to comply with the study requirements, or (3) the study sponsor decides to terminate the study.

Contacts and Questions:
- The researcher conducting this study is Patricia Yu. For questions or more information concerning this research you may contact me at [redacted].
- If you believe you may have suffered a research related injury, contact Patricia Yu who will give you further instructions.

- If you have any questions about your rights as a research subject, you may contact: Director, Office for Research Protections, Boston College at [redacted], or irb@bc.edu

Statement of Consent:
- **(**For Adult Consent Form or older child (12-17 years) combined Consent/Assent (Full form): I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received (or will receive) a copy of this form.