

*The experience of family caregivers and migrant paid caregivers relief of
burden: A contrasted qualitative analysis*

Carmen de la Cuesta-Benjumea DUE, Phd
Department of Health Psychology
University of Alicante
Ap 99
03080 Alicante
Spain
Tel: 965 903400
Fax: 965 903516
e-mail: ccuesta@ua.es

Brenda Roe PhD, RN, RHV, FRSPH
Evidence-based Practice Research Centre
Edge Hill University
Ormskirk
Lancs L39 4QP
England
Tel: 44 1695 650948
Email: Brenda.roe@edgehill.ac.uk
And
Personal Social Services Research Unit
University of Manchester
Oxford Rd
Manchester M13 9PL
England
Tel: 44 161 275 5680

Abstract

Older people are increasingly being cared for in the community across Europe. Dependent care in Spain largely remains a private issue involving family carers and migrant women from developing countries.

Qualitative research on respite care has contributed to our understanding of respite as a subjective experience. Nonetheless, how caregivers relieve the burden of care is still not fully understood. Migrant caregivers are present in family life but their need for rest remains unseen. The aim of the study presented in this paper was to contrast family caregivers and migrant caregivers' strategies for relief from their caring role.

Caregivers rest by thinking, doing and being but in a different manner from that of care giving, that is: when they are a different person. *To leave the life of care giving* is the general strategy that family caregivers use to rest from their care giving selves while *turning to one's own world* describes the way migrant caregivers seek to relieve the burden of care. The comparative analysis shows that both strategies have in common the necessity to disconnect from care giving identity and that, both migrant and family care givers employ strategies that are *false exits to a care giving identity*: they apparently relieve the burden of care. Respite goes beyond places, times and activities; as family care itself, it requires identity.

Key words: Carers, care giving, grounded theory, migrant caregivers, paid care, qualitative analysis, respite care, Spain

Introduction

With population ageing, older people are increasingly being cared for in the community by formal services and informal care, traditionally by family members (Hong, Hasche and Lee 2011; Litwin and Attias-Donfut 2009; Roe *et al.* 2001a, b). A predicted shortfall of family caregivers for older people in the community, due to changes in family commitments, locations and employment, is a concern in Europe and the USA (EPSCO 2007; Butler 2007).

The migration of women from developing to developed countries to provide care for the frail and dependent has become a global trend in response to the shortage of available family members as caregivers (Ehrenreich and Hochschild 2002). Latin American and Filipino women have been the focus of research studies in Europe, the East and the USA (for example Anderson 2000; Ayalon and Shiovitz-Erza 2010; Constable 2002; Gallart Fernández-Puebla 2007; Hochschild 2003; Salazar-Parreñas 2001) showing that this global trend has traits in common. Migrant women, usually, leave behind their own children in the care of relatives to serve and care for others in foreign places (Hochschild 2003; Salazar-Parreñas 2001; Mora and León-Medina 2011;) creating transnational families (Salazar-Parreñas 2001). Isolated in their employers' homes and facing what is often a depressing job, migrant women find solace in giving the love and care to those that they now care for (Hochschild 2003; Salazar-Parreñas 2001). With little or no social support at all, migrant women are often the main economic sources for their families (Hochschild 2003; Mora and León-Medina 2011).

Dependent care in Spain largely remains a private issue involving family carers, predominantly women (de la Cuesta-Benjumea 2011). While there has been an increase of formal services, the role of the state remains residual, for instance 76 per cent of dependent people receive support only from their relatives (IMSERSO 2011). The care giving structure reflects what is being labelled as “Mediterranean culture” where women are at the centre of care and the providers of family welfare (IMSERSO 211:641). Figures for Spain have not changed much over the past 20 years, wives and daughters comprise 84 per cent of all caregivers with a mean age of 52 years but they are getting older, with 22 per cent reported being more than 60 years of age (IMSERSO 2011). Although in 2007 a law was passed to support family caregivers (Ley 39/06), this has shown important shortcomings in practice. Support in the form of either developing formal services, providing home services or economic reimbursements for caregiver’s work, is not reaching those who need it and there are important differences across the country in the implementation of this law (Garcés *et al.* 2010). The present economic climate has worsened this situation.

Over the past two decades, an important number of women from developing countries care for older people in Spain (Gallart Fernández-Puebla 2007). A study estimated that migrant women care for 90 percent of older people in Madrid (Rodríguez-Rodríguez *et al.* 2010). Migrants usually work as live in caregivers, spending twenty four hours a day with the dependent person (Berjano-Peirats, Simó and Ariño-Villaroya 2005), an important number are illegal, forced to live in exploitative conditions (Vicente and Setién 2005).

Families are not usually concerned about their experience or training in care giving as this is compensated by migrants' personal and social skills (IMSERSO 2011). Indeed, caregivers from Latin American countries are much appreciated because of their personal qualities such as kindness and sweetness (Colectivo loé 1999; Parella-Rubio 2003). It is their personhood rather than their labor force that is being hired (Andreson 2000). Resorting to migrants to care for dependents is not unique to Spain, in Germany it is estimated that 100 000 families receive unregistered home care from nurses coming from Eastern European countries (Boeckxstaens and De Graaf 2011). Studies of migrant caregivers for older people are available from other European countries, the Middle East and Africa (Badr and Shah 2011; Doyle and Timonen 2009; Van Der Geest, Mul and Vermeulen 2004; Zechner 2008). Their presence exhibits a private solution to the care deficit public problem and is changing the structures of care giving.

Background

The impact of care giving on caregivers' health has been widely acknowledged (del Pino-Casado *et al.* 2011; McMunn *et al.* 2009; Tolkacheva *et al.* 2011). As many as 85% of caregivers recognize the negative effects that caring for a dependent relative has on their lives (IMSERSO, 2005). What affects them most is the lack of free time and not being able "to go on holidays" (IMSERSO, 2005: 44). Even so, some conditions are worse than others; caring for a relative with dementia is known for the strain that it puts on families and the burden of care is much higher than caring for people who have other conditions (Andrén and

Elmstähl 2008; Miura, Arai and Yamasaki 2005; Shim, Landerman and Davis 2011). The literature has reflected caregivers' mechanisms to cope with that burden depicting them as active agents involved in a process of solving everyday care giving problems (Ekwall, Sivberg and Hallberg 2007; Salin, Kaunonen and Ästedt-Kurki 2009). Nevertheless, the need for caregivers to have respite is unquestioned and respite care has been developed to help caregivers. However, respite services may not be widely available or not accessed (Shaw *et al.* 2009). Studies have pointed out contextual issues that inhibit the use of respite services (de la Cuesta-Benjumea 2010; Lilly *et al.* 2012). A recent qualitative study found that caregivers of relatives with dementia were worried for their relative's safety in an unfamiliar environment and felt anxious about the public recognition of their relatives' condition and embarrassment that this might cause to them (Robinson *et al.* 2012).

Although migrants classify themselves as the "primary caregivers" they are considered as help and respite for family caregivers (IMSERSO 2005). In terms of burden of care, studies found that they are even more vulnerable than family caregivers (Gallart Fernández-Puebla 2007; Gallart Fernandez-Puebla, Sanchez-Cruz and Yarnoz-Zabalegui 2012). They are separated from their families, their culture and social networks, adapting to the host country which can be stressful and have a negative impact on their health; they experience emotional and social loneliness (Ayalon and Shiovitz-Erza 2010). On top of that, their working conditions are poor (Lassetter and Callister 2009; Negy, Schwartz and Reig-Ferrer 2009; Gallart Fernández-Puebla 2007) and are intensified by their work being behind closed doors, in someone else's home (Ayalon and Shiovitz-Erza

2010). Whether or not they are living in their employer's home and whether or not they have legal permission to work, are the two factors that have a significant impact on their living and working conditions (Anderson 2000). Migrants are more exposed to health damaging work environments than native workers and their status is considered a source of global health inequalities (Benach *et al.* 2011). They are treated as invisible workers, with low status and often are exposed to abuse and negative working conditions (Ehrenreich and Hochschild 2002; Hochschild 2003). Their burden of care is a matter of concern, and as with family caregivers, it affects their health and the quality of the care they provide.

Qualitative studies are focusing on respite as a process and outcome and are contributing to our understanding of the experience of caregivers' and their need for rest. Nonetheless, how caregivers relieve the burden of care needs to be further understood (de la Cuesta-Benjumea *et al.* 2006). Migrant caregivers' invisibility is still conspicuous, they are present in family life but their experience and need for rest remains unseen.

The present study was aimed at comparing and contrasting family caregivers and migrant caregivers' points of view and their experiences of relieving the burden of care. It has drawn on the results from two complementary studies on women family caregivers strategies for the relief of burden in advanced dementia (de la Cuesta-Benjumea 2011) and migrant women caregivers strategies for relief from their care giving role (de la Cuesta-Benjumea, Donet-Montagut and Galiana-Gomez de Cádiz 2012). They formed part of a larger

study on the burden of care in situations of vulnerability (de la Cuesta-Benjumea *et al.* 2006).

Method

Aim and design

This study was the ensuing phase of the larger study into burden relief in situations of vulnerability focusing on family caregivers of people with dementia and migrant caregivers of very dependent elderly. The purpose of the main study was to describe the contexts and ways that caregivers use to relieve the burden of care and encompassed two separate but complementary studies, one aimed at describing migrant caregivers and the other, family caregivers' strategies and conditions for relieving the burden of care. Both studies shared similar methodology but were conducted separately. The migrant caregivers cared for people with a range of conditions while the family caregivers cared for people with dementia. Migrant and family caregivers were interviewed and invited to write about their experiences of relieving the burden of care and grounded theory techniques guided data analysis (Glaser and Strauss 1967; Strauss 1987; Charmaz 2006).

The aim of the study presented in this paper was to contrast family caregivers and migrant caregivers' strategies for relief from their caring role that were previously uncovered in the early phases of the larger study.(de la Cuesta-Benjumea *et al.* 2006). The categories and sub-categories that emerged from

the two separate studies were the data sources and were contrasted using grounded theory comparative analysis.

In grounded theory categories and subcategories are the product of analysis. Categories explicate ideas, events or processes in data; sub-categories subsume common themes and patterns in a given category (Charmaz 2006). Categories might be integrated into a core category that encompasses the concepts uncovered during analysis (Glaser 1998). Grounded theory is in fact a way of conceptualizing data at different levels. According to Glaser (1998) it is a third level conceptual analysis. The first level is the data, the second is the conceptualization of data into categories and subcategories and the third is the overall integration into a core category. This conceptual work is not conducted during field work but during coding, writing preliminary analysis, and sorting categories and sub-categories into an integrated theory (Glaser 1998). The general strategy for uncovering categories is the constant comparison where first incidents to incidents are compared, then incident to concept and lastly concepts to concepts (Glaser 1998).

Data sources

Participants in the studies were 23 women family caregivers of relatives with advanced dementia (de la Cuesta-Benjumea 2010, 2011) and 17 migrant women paid caregivers of very dependent persons (de la Cuesta-Benjumea, Donet-Montagut and Galiana-Gomez de Cádiz 2012). Participants were purposely sampled; also snowball sampling was used to identify those migrant caregivers with the widest and richest experience of care giving (Morse 1989).

Although they cared for people with different conditions and had different relationships, the level of care required in common was of high dependency. The case of family caregivers was - advanced dementia and the case of migrant caregivers was - being employed due to the enduring and intensive care of the dependent person. Hence, care recipients were completely dependent in activities of daily living, required constant assistance and supervision and were housebound. Participants were all women recruited with the assistance of health services professionals from various health centres and through non-governmental migrant organizations. Sampling was sequential. As analysis proceeded the emergence of variations was favoured, and caregivers with different kin relationship, levels of education and care giving situation were sought.

Migrant caregivers were part of extended families; in most cases they had small children that were left in their countries of origin in the care of a relative. Their legal status was both documented and undocumented. Family caregivers tend to be daughters living with the sick person receiving little support from their families and the state. In general, their income did not permit them to hire a person to assist them.

Caregivers participation was voluntary and fully informed and consented. Ethics approval for the studies was granted by the University Research Committee. To preserve anonymity, pseudonyms are used in the findings. Data were obtained between November 2006 and March 2009. In total, 35 semi-structured

interviews were conducted, 5 written testimonies collected and one group discussion conducted to validate results.

Questions guiding interviews with both groups were similar. Participants were asked to relate their experience of burden relief and to elaborate on the strategies they use to achieve rest (see Box 1 and 2). Interviews were conducted in convenient places chosen by participants and lasted from 40 to 90 minutes. All interviews were tape recorded and transcribed verbatim.

Analysis proceeded concurrently in each of the studies with data collection using grounded theory procedures (as described above) categories and sub-categories emerged and saturation reached. Each study had a team of researchers and was coordinated by the principal researcher. Analysis proceeded independently in each study to ensure the emergence of categories. Discussion and consensus was used in each study to agree on categories.

Data analysis and synthesis

Categories and subcategories were contrasted using the constant comparative analysis proposed in grounded theory (Glaser and Strauss 1967; Strauss 1987) and were re-conceptualized reaching a third level of analysis, that is, where a core category enables the organization of the other categories (Glaser 2002), in our case the core category was "Distancing oneself from a care giving identity". Similarities and differences of the categories that emerged during the early phases of the larger study were noticed, grouped and coded at a higher level. Advanced memos were produced during this phase of analysis; diagrams and

clusters helped to visualize the relations among the contrasted categories (Charmaz 2006; Glaser 2002).

Validity was assured by grounding the analysis in data sources and by validating the emerging core category with data from the partial studies. Finding a negative case to this core category contributed to its saturation and rigour of the analysis. Health professionals in contact with family caregivers and migrant caregivers saw the relevance of the category during its presentation in different meetings. Discussion and consensus was also used to agree the core category that emerged.

Findings

Table 1 presents and contrasts the samples characteristics. Similarities and differences were identified in their approaches to relieving the burden of caring. Table 2 presents the original categories and sub-categories and highlights the similarities and differences found as part of this comparative analysis. Rest for caregivers does not imply being idle and on the contrary showed that caregivers rest by thinking, doing and being but in a different manner from that of care giving, that is: when they are a different person. *To leave the life of care giving* is the general strategy that family caregivers use to rest from their care giving selves while *turning to one's own world* describes the way migrant caregivers seek to relieve the burden of care (de la Cuesta-Benjumea, Donet-Montagut and Galiana-Gomez de Cádiz 2012; de la Cuesta Benjumea 2011). Both strategies are context bound hence, before contrasting them the context is examined.

Different contexts a similar experience

In family caregivers' experience there is an "after" and a "before" care giving denoting that before they had a life which has now disappeared or being substituted for another that they feel is not "normal" and this happened without moving from their homes or towns. Theirs is an altered life. Now they are tied to care giving, feeling "trapped" in their homes and "with no freedom". Due to the nature of dementia, caregivers' lives increasingly focus on care giving activities and duties to a point that they have no life of their own, as one participant said "it is as if you step out of life....you don't really live it" (Carmina, Spanish, 41 years old, takes care of her mother with dementia). Family caregivers' lives now run parallel to the lives of other family members; care giving takes practically all the space in their lives. They have no time for themselves or a private space where to be themselves. Caregivers have renounced to what was theirs:

I did not get out anymore... the disease developed so quickly! And then you do not have a life of your own! I would go out to have coffee but not going out with friends or go for a trip with them or with my boyfriend or say "I am going to do a normal life". No, I have to restrict myself (Maria, Spanish, 37 years old, takes care of her mother with Alzheimer Disease (AD)).

However, this experience is modulated by the family support caregivers have. As a participant explained "it is family harmony, how one relates to siblings, what will help or not at all" (Carmina, 41 years old, takes care of her mother with dementia). Sharing care among the family members will permit caregivers

retaining a life of their own. For instance, Rosa explained during the interview that they are three sisters and they take care of their sick parents on rota basis, about once a month, and for a week, one of them moves into their parent's home (Rosa, 52 years old takes care of her mother with AD and her father with problems of mobility).

The migrant caregivers' context is that of frustrated expectations. They left their countries, families and migrated with the hope of finding a good job and a salary that would permit them to save enough money and return to their countries (Galiana Gómez de Cádiz & de la Cuesta-Benjumea 2008). Theirs is a dislocated life. On arrival they found an unexpected situation, low salaries, and poor working conditions; unlike family caregivers, they do not have social network to help them shoulder the care giving work. They felt trapped, having to endure and adjust their initial expectations. As with family caregivers, due to their migration and working conditions their present life is not normal. Nevertheless, migrant caregivers keep close ties with their families in their countries of origin and with migrant friends. While family caregivers have lost their regular lives, migrant caregivers are away from them. As one participant put it:

It is very hard. I miss a lot my family, this is constant, and I know how to spend the hours and days (without them) but on Sundays at night is when I miss them most, but time passes by reading or when speaking with my brothers (Edith, Paraguayan, 35 years old, husband and children live in country of origin).

Nonetheless, caregivers might find better conditions in the host country than theirs of origin as Kira, 30 years old, explained. She arrived from Romania in a good home where she feels like a daughter, has a better salary than the one she had received in Romania where she worked very hard as a caregiver and now has regular daily breaks from care giving. She lives with her boyfriend and has been able to build a parallel life from that of care giving. As a member of the European Union she does not have the difficulties other undocumented migrant caregivers have. On top of that, she can help her family in Romania economically; their basic needs are covered with the money she regularly sends. Her life is not altered nor dislocated, but improved from the life she had before, not surprisingly she feels “very happy”. This case illustrates the importance of working conditions in migrant care giving, and how they can alter the whole experience of being a migrant care giver.

For participants, their families are both the cause of initiating migration and a source of strength to endure the burden of care. To help their families and “bring them their bread”, as they said during the interviews, gives them a purpose in life. This makes the difference with other types of caregivers, as one participant explains:

Laura-One knows that [what she does] is work and that thanks to this work one is feeding many people, one is feeding her son, her brother, her mother. Then, one has to think that thanks to this older person one has this job and is feeding her children, then one thinks in that way and it gives you more life; it gives you spirit and

determination to carry on because what you are doing is for your children.

Q-Well, but there are people who came to this country with no children

Laura-But those with no children in fact care for dependent elderly for three, four months and no more, then they do not support it anymore because there is a lot of responsibility...if they do not have children, they do not last so long... we have to endure for our children, it is for them (Laura, 27 years old, Paraguayan, their children live in country of origin).

Distancing one self from a care giving identity

The comparative analysis shows that in order to relieve the burden of care, migrant and family care givers have in common the need to distance themselves from a care giving identity. A caregiver expressed this by saying that she has to go out and “forget” what she leaves behind (Marta, Spanish, 62 years old, takes care of her mother with AD). Many other family caregivers expressed that they have to “disconnect” from care giving, but in fact, in order to rest, caregivers do have to connect to other selves. The ways and means migrant and family caregivers employ to do that are different.

Migrant caregivers rest is linked to the fact that they live in a country that is not their own, away from their families and separated from what belongs to them. To rest for them, will imply a return to their preserved identities and places, this return can be a virtual one when they use t information technologies. The

*locutorio*¹ is a place where they can speak to their children and even see them via the internet. As Edith said, when she connects with her family it is like “breathing” and this keeps her alive. Participants go to *locutorio* regularly “twice or even, three times a week” as Amalia acknowledged during the interview (Bolivian, 24 years old, her children live in Bolivia). Going to the *locutorio* is like returning to their homes and to their identities as mothers or wives; via the internet and the phone mothers can follow their children’ school progress, celebrate their birthdays and, in sum, care for them – albeit at a distance. In addition going to the *locutorio*, involves a break from the place where they stay the whole day:

Q-You said you come back “as new” because you have spoken to your son or because you have taken some air?

Laura-Both, I have talked to my son and I get out of the house for a while because being lock in the house drives me mad, is something I cannot stand (Laura, 27 years old, Paraguayan, their children live in country of origin).

Another mechanism that migrant caregivers use to relieve the burden of care is retiring to places of their own. These could be their bedroom in the home where they are in private to call in their minds what is theirs, imagine their children and speak to them, for some moments they are away, in their imagination connected to their family. Also they go out to share flats where they stay with relatives or peers during their free days or days off. In all these outings participants connect to their felt identity and this provides the needed rest. The break is from being a migrant caregiver:

Q-Being with your own family is how you did recover?

Ester- Yes, the [working] day passed quickly (Bolivian, 52 years old, her family lives with her in Spain).

When they return to their countries of origin for a visit their care-giving identity fades away, participants are truly themselves meeting their own kin; these visits are true breaks from care giving, the effect is that of feeling life more intensively: "To come back to what belongs to you gives you a lot of vitality" concluded Teresa (Uruguayan, 27 years old, all her family lives in country of origin).

Family caregivers, on their part rest by taking on other identities some of them postponed and others lost. To rest or have respite here is not so much about going out to places as with the migrant caregivers; the crux is changing the self so they can distance themselves from a care giving identity. Hence, activities that can be considered "work" can, paradoxically produce rest, a caregiver explains:

The way I clear my head is by going to my home and organizing things at home! (Laugh). It is not a time for my self, but it is time for my home! Time for my daughters and for my husband! (Laugh) but time in inverted commas as neither my daughters nor my husband is at home at this time of the day (Veronica, Spanish, 50 years old, takes care of her father with AD).

So family caregivers rest when they act as mothers, grandmothers or when they are intimate with their husbands. Staying with their friends or studying, can also

provide some rest. In these situations caregivers take on alternative selves so they can be “others” as a participant said. Being another person can occur in the very same place where care giving occurs. This is clearly shown when caregivers relate that they rest when engaging in activities with their sick relative such as watching TV together or reading to them. In this way, caregivers relate to their relative not as caregivers but as a kin and this provides moments of rest.

The family is an important source of alternative identities in both cases, the relationships that they establish with them provides a break from being a caregiver. However, migrant and family caregivers are constrained to connect to these alternative selves. Most of these difficulties come from migrants' labour conditions and the family commitments family caregivers agree upon. The long working hours, the permanent availability and the little opportunities that migrant caregivers have to socialize restricted their opportunities to be someone different, to resort to their mind to recreate others is thus understandable and shows caregivers resourcefulness to create symbolic places to rest. It was not unusual for participating family caregivers to agree upon economic arrangements in exchange for care giving such as keeping their parents pension or inheriting the apartment after their death. The salary, in these cases, was received in advance. These economic arrangements altered their kin status in relation to other family members, caregivers felt constrained to ask for respite as Juana commented during the interview (Spanish, 52 years old, care for her mother with AD) or felt as if they were taking advantage of the situation by asking for respite breaks as Carmina said (41 years old, takes care of her

mother with dementia). These economic arrangements reinforced the moral obligation caregivers felt making it very difficult for them to escape from their caregiver's identity.

Hence, to distance oneself from care giving is not easy. Neither relationships nor places guarantee caregivers' rest. This contrasted analysis shows that there are *false exits to a care giving identity* as they apparently distance participants from care giving. Thus, migrant caregivers express that their employers treat them "as if" they were family and that they relate with the sick person "as if" they were a relative, employers trust them. A participant commented:

I do not feel the pressure of being controlled and questioned if I am doing wrong with *granny*, it is not that I am overstepping my role but the issue is that they [employers] treat me *as if* I am one member of the family, as another *sister in their home* who is taking care of her mother (Nuria, Chilean, 54 years old, husband, children and grand children live in country of origin. Emphasis added)

But these fictitious identities keep migrant caregivers connected to care giving as this bond is established when providing care for the dependent person, as the quote shows. In addition, it put them at risk of being emotionally exploited, increasing in this way their burden of care. A participant acknowledged that she felt she could not cope with the burden of care but, with gratitude, did not tell the employing family. For loyalty to the family, in her own words: she "would endure more than I could" (Irene, Chilean, 52 years old, lives in own apartment with her children), the affective bond with the care recipient also contributes to

caregivers' exhaustion (Laura, 27 years old, Paraguayan, their children live in country of origin). The home can also be a fictitious place that provides rest although not a true rest, as a participant explains:

Irene-We are there, 24 hours a day. It is as if it is our own home, where one can sit in the sofa and not attending request, closes the door, lies down, sleeps and do as ones pleases. This is something one can do on her own home! But if one is going to do this type of work and is alone with Mercedes [the patient] the entire house at my disposal! I was the owner of the house! It was my kingdom but it was not my house, I was working.

Q-Hence you did have a real rest.

Irene-No.

Q-When did you have it?.

Irene- Now, in my own home....if I get tire I go for a lie down. (Irene, Chilean, 52 years old, lives in own apartment with her children).

Family caregivers, on their part, stated that, there are occasions that they go away but remain "connected" to care giving. Thus they are physically in another place but worrying and wondering about what they left behind. Some participants stated that the cared for person is 'in their head' (Adela, Spanish, 62 years old, cares of her mother with dementia) all of the time and they constantly make phone calls to see if everything is all right or keep watching the cell phone for messages. In other cases family caregivers go out for short walks and find themselves unoccupied and at a loss with themselves. They have no one to talk with, with no self to act upon. These outings do not provide relief as

participants acknowledged, sometimes they returned from short breaks even more tired and feeling very lonely. As opposed to migrant caregivers, family caregivers have not been formally employed to care for the dependent person; for them, resting is not clearly legitimate (de la Cuesta-Benjumea 2010). The verbal indicator of these false exits is when family caregivers speak of achieving rest “in inverted commas” and migrant caregivers speak of “a different rest” than the one they experience when they are in their own homes and with their own kind.

Discussion

Humans develop selves, during childhood and throughout life, which enter virtually in all actions and in varied ways (Mead 1972). This study has shown the different selves that caregivers can act upon and the importance of others for caregiver's identity. Indeed, the others are essential for having a sense of self; a person cannot be in a vacuum, and identity is socially achieved (Blumer 1969). In the case of women, their identity as carer is moulded through the services they provide to the dependent (Graham 1983). To achieve rest, acting upon other selves is the key; the present study has illustrated the different mechanisms that caregivers use to regain different selves. These selves are gendered; they illustrate women's concerns for the well being of others.

Family care is more than just actions and activities and implies relationships that demand identity and work (Carter 2001; Graham 1983). Caring is a labour that encompasses emotional bonds and ensures life (Graham 1983). It

demands an adoption of a lifestyle which isolates caregivers from the outside world (Abel and Nelson 1990; Finch and Groves 1983). Caregivers' work is dictated by the times of the dependent person's needs; caregivers feel powerless to control the conclusion of their care giving responsibilities, for many it is a boundless activity (Abel 1990). However, due to their legal and employment situation, migrant's caregivers have less capacity, to control the shape of their work and the demands placed upon them (Abel and Nelson 1990).

Previous studies have emphasized the need for caregivers to have time for leisure, to be relieved from care giving duties and to get breaks from care giving (Lilly *et al.* 2012; Robinson *et al.* 2011; Upton and Reed 2005). Women's identity is essentially relational (Abel and Nelson 1990). Our comparative analysis and synthesis has highlighted that both family and migrant caregivers need to be connected to activities and people that enable them to be recognized as women, mothers, daughters, students or professionals, However, they have limited opportunities to interact with others while in the home and being confined limits their chances to create social bonds. If not truly connected to others, relief might be only achieved on the surface. By contrasting family and migrant caregivers' strategies this study has reinforced the importance of relationships in burden relief and the need to have alternative selves to that of a caregiver. While for family caregivers this implies the need to retain their regular lives, for migrant caregivers this implies the need to have their work regulated.

Several studies have uncovered caregiver's coping strategies (Ekwall, Sivberg and Hallberg, 2007; Nolan, Grant and Keady 1996; Salin, Kaunonen and Åstedt-Kurki, 2009) but little has been said about strategies or activities that fail to produce the needed rest. The contrasted analysis and synthesis presented in this paper has uncovered this issue under the category of false exits. Family caregivers might go out but to a void. They lost their regular lives and now have no one to relate with, but other caregivers. In spite of being away from their caregiving duties and having time to rest, they do not really rest. Others are not there to enable them to feel a different self. Migrant caregivers might be treated as a family member but their emotions being put into service; that is, being emotionally exploited (Hochschild 2003) . Under the appearance of being a member of the family, they are in fact requested to go beyond their contractual duties and move into the kinship realm where labor is also emotional (Ehrenreich and Hochschild 2002). This might entitle the employer to encroach their off duty hours (Anderson 2002). The migrant caregiver, as the domestic worker does, occupy a symbolic space between the public and the private; she is treated as "part of the family" and as worker according to her employer's interests (Anderson 2002). In fact, she is expected to provide additional caring tasks with no additional cost to the employer and care at the expense of her own social needs (Ayalon 2009). While this might help them to cope with loneliness (Ayalon and Shiovitz-Erza 2010) the present study shows that, in the long run, adds to the burden of care.

Frequently, the immigrants are not recognized as caregivers, but are referred to as domestic workers, or as informal family support (IMSERSO 2005; Pià- Julià

et al. 2007). This study has considered them as caregivers and highlighted the points that they have in common with family caregivers. No other studies have approached them in this manner. This highlights the need for migrant caregivers to be included as partners in care provision which is the recommendation for family caregivers (Lilly *et al.* 2012; Nolan, Grant and Keady 1996).

The support that migrant caregivers give to their family is being well documented under the concept of transnational care (Baldassar 2007; Salazar-Parreñas 2001; Zechner 2008); it refers to all the forms of care and support that families exchange (Baldassar 2007; Salazar-Parreñas 2001; Zechner 2008).

The emotional and moral support that migrants receive has been well described in the literature (Baldassar 2007, 2008; Wilding 2006); the present study has highlighted its relevance for enduring migrant's working situations and for providing them with respite. Communication technologies have been identified as key in providing emotional support and in maintaining migrants' sense of being part of their families albeit at a distance (Baldassar 2007, 2008; Wilding 2006; Zechner 2008), technologies provide opportunities for a shared co-presence (Baldassar 2008). The present study has shown that they provide the opportunity for resting from a care giving identity and has identified the *locutorio* as the place where most of the transnational care exchanges take place. Here communication technologies are united, where migrants can phone and use the internet at very low cost and send remittances. The importance of migrants' visits to their homeland in transnational care giving has also been documented (Baldassar 2008), the present study has revealed them as a way of achieving respite from care giving and helps them to continue care giving.

Early literature paid attention to women's entering into care giving out of a sense of obligation (Finch 1989) and studies have described the mechanisms that keep this obligation operating (Finch and Groves 1983; Robles-Silva 2007). Migrants' obligations to care for their families, in both in the host country and in their countries of origin, have been uncovered in previous studies (Anderson 2001, 2002; Ayalon 2009; Wilding and Baldassar 2009). The present study shows that migrants could experience a double sense of obligation: to their own families and to their employers' when they feel as part of the family. Here, their ties to care giving are strong and hard to lose to relief their burden of care.

Migrant care givers usually work with no contracts and this impacts on their well being (Anderson 2000; Vicente and Setién 2005). This illegal situation has consequences that employers need to be aware of. Urgent health issues that must be addressed among migrant workers are occupational safety, injury prevention, work related diseases, discrimination and exploitation (Benach *et al.* 2011; Gallart Fernandez-Puebla, Sanchez-Cruz and Yarnoz-Zabalegui 2012); all of them relevant in care giving. The need for improvements in paid caregivers working conditions and to regulate this workforce has been voiced in the literature (Gallart Fernandez-Puebla, Sanchez-Cruz and Yarnoz-Zabalegui 2012; King, Parsons and Robinson 2012) as well as the need for promoting visits to their countries of origin and family reunions (Hoschild 2003). The present study has highlighted how this regulation will contribute to the relief of burden and shown the benefits that this could have to their health. By maintaining links and connections with their peers and relatives, migrant

caregivers do keep their own identities alive and such actions are like places of rest and act as respite.

Limitations of the study

Qualitative research does not aim at generalizing but at describing in depth a given experience from participants' points of view. The comparative analysis contrasted two groups with the common experience of caring for a dependent person in adverse conditions but with notable differences among them. By focussing on the common issues of the groups during analysis, some nuances were lost. Data from migrant caregivers were less in amount and descriptiveness. During interviews it was difficult to get rich and descriptive data from them, as they were not always comfortable discussing rest. This may have affected the validity of data gathered and contrasted.

Conclusion

Care of frail and dependent older people is a global issue and women's migrating to care for them is a global trend. Migration moves from the south to the north and from the east to the west, it affects us all. While paying for care is an alternative for few, the relief of the burden of care is a concern of all. Both migrants and family caregivers share the difficulties in relieving the burden of care. Health professionals and policy makers must pay attention to the fact that, in relieving the burden of care, differences among the two sorts of caregivers are blurred.

Respite goes beyond places, times and activities; as family care itself, it requires identity. Therefore, to contribute to caregiver's relief of burden, health and social care professionals must promote caregivers' leisure activities, rest and regular breaks from caring and their involvement in different social roles. Health and social care professionals, nurses in particular, have an authorized voice and are in special positions to detect caregivers' needs for rest and can contribute to raise general awareness of migrant paid caregivers needs for rest. In particular, they should encourage families to allow them enough free time and opportunities to link with their families and meet with their own social networks. The importance of regular visits to their countries of origin must also be stressed. In addition, health care professionals are in an ideal position to convey to care recipients and families the difficulties that led to migration and the consequences that these have for their emotional and physical health. Attention must be given to those strategies that are false exits disguised as rest which can actually add burden to caregivers.

We can reduce the cost of care giving. Care giving needs to move beyond the private arena into public policy, especially the development of strategies and programmes to support caregivers and the provision of respite. Otherwise respite will remain an almost self care activity. Migrant paid care giving must be regulated and labour policies developed within countries. Regulation will diminish migrant care givers vulnerability, improve their working conditions and, last but no least, improve the quality of services and care of older people they care for in the community.

Although health problems associated with care giving are well understood, less is known about effective interventions to support care giving work, this is an area of future research. Respite services and programmes need to be under scrutiny, evaluative research in this area seems to be much needed. Family care is an increasingly complex issue, with new actors entering the field. Qualitative research has much to offer to better understanding the experience and needs of caregivers. Migrant caregivers ought to be included in studies about family care alongside others such as kinship caregivers and paid caregivers.

References

Abel, E.K. 1990. Family care for the frail elderly. In Abel, E. K. and Nelson M. K. (eds), *Circles of care. Work and identity in women's lives*. State University of New York Press, New York, 65-91.

Abel, E. K. and Nelson M. K. 1990. Circles of care: An introductory Essay. In Abel, E. K. and Nelson M. K. (eds), *Circles of care. Work and identity in women's lives*. State University of New York Press, New York, 4-34.

Anderson, B. 2000. *Doing the dirty work. The global politics of domestic labour*. Zed Books, London, New York.

Anderson, B. 2002. Just another job? The commodification of Domestic Labour. In Ehrenreich, B. and Hochschild A. R. (eds), *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Metropolitan Books, New York. 104-14.

Ayalon L. 2009. Family and family-like interactions in households with round-the clock paid foreign carers in Israel. *Ageing and Society*, **29**, 05, 671-86.

Ayalon, L. and Shiovitz-Erza, S. 2010. The experience of loneliness among live-in Filipino homecare workers in Israel: Implications for social workers. *British Journal of Social Work*, **40**, 08, 2538-59.

Andrén, S. and Elmståhl, S. 2008. The relationship between caregiver burden, caregivers' perceived health and their sense of coherence in caring for elders with dementia. *Journal of Clinical Nursing*, **17**, 06, 790-9.

Badr, H. and Shah, M. 2011. Foreign live-in domestic workers as caretakers of older Kuwaiti men and women: socio-demographic and health correlates.

Ageing and Society, Available on line at:

<http://journals.cambridge.org/action//displayAbstract?fromPage=online&aid=8360540> [Accessed 26 April 2012].

Baldassar, L. 2008. Missing kin and longing to be together: Emotions and the construction of co-presence in transnational relationships. *Journal of Intercultural Studies*, **29**,3, 247-66.

Baldassar, L. 2007. Transnational families and support: The relationship between truth and distance. *Identities: Global Studies in Culture and Power*, **14**, 04, 385-409.

Benach, J. Muntaner, C., Delclos, C., Menéndez, M. and Ronquillo, C. 2011. Migration and "Low-Skilled" Workers in Destination Countries. *PLoS Med*, **8**, 6 e1001043. doi:10.1371/journal.pmed.1001043

Berjano-Peirats, E., Simó, C., and Ariño-Villaroya, A. 2005. Condicionantes de la aparición del fenómeno social inmigrantes que cuidan a mayores [Conditions leading to the social phenomena of migrant elder caregivers]. In IMSERSO (ed.)

Cuidado a la Dependencia e Inmigración. Informe de resultados [Care in dependency and migration. Report of results]. IMSERSO, Madrid, Spain, 21-119.

Blumer, H. 1969. *Symbolic Interactionism. Perspective and Method.* Prentice-Hall, Englewood Cliffs, New Jersey.

Boeckxstaens, P. and De Graaf, P. 2011. Primary care and care for older persons: Position Paper of the European Forum for Primary Care. *Quality in Primary Care*, 19, 06, 369-89.

Butler, R.N. 2007. Who will care for you ? By 2030 the United States will need between 5.7 million and 6.6 million caregivers. *AARP Bulletin*. January.

Available on line at

http://www.aarp.org/relationships/caregiving/info_2007/who_will_care_for_you.html [Accessed on 26 April 2012].

Carter, C. 2001. The family caring experiences of married women in dementia care. In Adams, T. and Clarke, C. (eds). *Dementia care. Developing partnerships in practice.* Baillière Tindall, London, 187-208.

Charmaz, K. 2006. *Constructing Grounded Theory. A practical guide through qualitative analysis.* Sage, London.

Colectivo loé. 1999. *Inmigrantes, trabajadores, ciudadanos. Una visión de las migraciones desde España. [Migrants, workers and citizens. A vision of migration*

from Spain] Universitat de València, Valencia, Spain.

Constable, N. 2002. Filipina Workers in Hong Kong Homes: Household rules and relations. In Ehrenreich, B. and Hochschild A. R. (eds), *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Metropolitan Books, New York. 115-41

de la Cuesta-Benjumea, C., Galiana-Gomez de Cádiz, M.J., Donet –Montagut, T. and Luzán, M.J. 2006. *Cuidado familiar - Alivio de la carga en situaciones de vulnerabilidad: Mujeres cuidadoras de pacientes con demencia avanzada y mujeres inmigrantes que proporcionan cuidados familiares*. Proyecto de investigación aprobado por el Fondo de Investigación en Salud, Ministerio de Sanidad y Consumo-PI 060005, Madrid, España. [*Family Care - Relief of burden in situations of vulnerability: Women caregivers of patients with advanced dementia and immigrant women caregivers*. A research project approved by the Health Care Research Fund of the Ministry of Health and Consumer affairs- PI 060005.Madrid, Spain].

de la Cuesta-Benjumea, C. 2010. The legitimacy of rest: Conditions for the relief of burden in advanced dementia care giving. *Journal of Advanced Nursing*, **66**, 05, 989-98.

de la Cuesta-Benjumea, C. 2011. Strategies to relieve burden in advanced dementia care giving: a qualitative interview study. *Journal of Advanced Nursing*, **67**, 8, 1790-9.

de la Cuesta-Benjumea, C., Donet-Montagut, T. and Galiana-Gómez de Cádiz, M.J. 2012. "Turning to one's own world: escape mechanisms employed by immigrant caregivers in Spain for relieving the burden of care. *Journal of Transcultural Nursing*, **23**, 01, 56-64.

del Pino-Casado, R., Frias-Osuna, A., Palomin-Moral, P.A. and Pancorbo-Hidalgo, P. L. 2011. Coping and subjective burden in caregivers of older relatives: a quantitative systematic review. *Journal of Advanced Nursing*, **67**, 11, 2311-22.

Doyle, M. and Timonen, V. 2009. The different faces of care work: Understanding the experiences of the multi-cultural care workforce. *Ageing & Society*, **29**, 03, 337- 50.

Ekwall, A. K., Sivberg, B. and Hallberg, I. R. 2007. Older caregivers' coping strategies and sense of coherence in relation to quality of life. *Journal of Advanced Nursing*, **57**, 06, 584-96.

Ehrenreich, B. and Hochschild, A. R. 2002. Introduction. In Ehrenreich, B. and Hochschild A. R. (eds), *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*. Metropolitan Books, New York. 1-13.

Employment, Social Policy, Health and Consumer Affairs Council of the EU (EPSCO).2007. *1 Issue: Joint report on social protection and inclusion*. no. doc: 6097/07 SOC 42 ECOFIN 58 FSTR 3 EDUC 28 SAN 18; no. prop: 5553/07.

Available on line at <http://register.consilium.europa.eu>

[/pdf/es/07/st06/st06694.es07.pdf](#) [Accessed 26 April 2012]

Finch, J. 1989. *Family obligations and social change*. Polity Press, Cambridge, UK.

Finch, J. and Groves, D. 1983. Introduction. In Finch, J. and Groves, D. (eds) *A labour of love, women, work and caring*. Routledge & Kegan Paul, London, 1-10.

Galiana Gómez de Cádiz, M.J. and de la Cuesta Benjumea, C. 2008. "Sabemos a lo que venimos": Expectativas frustradas y ajustadas de las cuidadoras inmigrantes. *Jornadas Internacionales de cultura de los cuidados*, Universidad de Alicante, Alicante, España, 12/06/2008. [We we know what we came for: frustrated and adjusted expectations. *International conference on cultural care*. University of Alicante, Alicante, Spain 12/06/2008]

Gallart Fernández-Puebla, A. 2007. *Sobrecarga del cuidador inmigrante no profesional formal*. Tesis Doctoral. [Care giving burden of non professional migrant caregiver. Unpublished Doctoral Thesis dissertation] Universitat Internacional de Catalunya. Sant Cugat, Barcelona, Spain.

Gallart Fernandez-Puebla A., Sanchez Cruz, .F and Yarnoz Zabalegui, A. 2012. Factors influencing burden among non-professional immigrant caregivers: a case-control study. *Journal of Advanced Nursing*, Article first published online: 6 JUN 2012 DOI: 10.1111/j.1365-2648.2012.06049.x

Garcés, J., Carretero, S., Ródenas, F. and Vivancos, M. 2010. The care of the informal caregiver's burden by the Spanish public system of social welfare: A review. *Archives of Gerontology and Geriatrics*, **50**, 03, 250-53.

Glaser, B. 1998. *Doing Grounded Theory: Issues and Discussions*. The Sociology Press, Mill Valley, California.

Glaser, B. 2002. Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1, 2, Article 3. Available on line at: <http://www.ualberta.ca/~ijqm/> [Accessed 4 April 2010]

Glaser, B. and Strauss, A. 1967. *The Discovery of Grounded Theory: Strategies for qualitative research*. Aldine de Gruyter, New York

Graham, H. 1983. Caring: A labour of love. In Finch, J. and Gorfes, D. (eds). *A labour of love. Women, Work and Caring*. Routledge & Kegan Paul, London, 13-30.

Hochschild A.R. 2003. *The commercialization of intimate life. Notes from home and work*. University of California Press, Berkeley, Los Angeles, London.

Hong, S., Hasche, L. and Lee, M.J. 2011. Service use barriers differentiating care-givers' service use patterns. *Ageing & Society*, **31**, 08, 1307-29.

Instituto de Mayores y Servicios Sociales (IMSERSO). 2011. *Envejecimiento Activo-Libro Blanco [Active ageing-A report]*. Ministerio de Trabajo y Asuntos Sociales, Madrid, Spain.

Instituto de Mayores y Servicios Sociales (IMSERSO). 2005. *Cuidado a la Dependencia e Inmigración .Informe de resultados.1st Edition [Caregiving in dependency and immigration. A research report]*. Ministerio de Trabajo y Asuntos Sociales, Madrid, Spain.

King, A., Parsons, M. and Robinson, E. 2012. A restorative home care intervention in New Zealand: perceptions of paid caregivers. *Health and Social Care in the Community*, **20**, 01, 70-9

Lassetter, J. H. and Callister, L.C. 2009.The impact of migration on the health of voluntary migrants in Western Societies: A review of the Literature. *Journal of Transcultural Nursing*, **20**, 01, 93-104.

Ley 39/ 2006. *Promoción de la Autonomía Personal y Atención a las personas en situación de Dependencia.*[Act 39/2006. *The promotion of personal autonomy and attendance to the persons in situation of dependency*] BOE 299,15 Diciembre 2006.

Litwin, H. and Attias-Donfut, C. 2009. The inter-relationship between formal and informal care: a study in France and Israel. *Ageing and Society*, **29**, 01, 71-91.

Lilly, M., Robinson, C., Holtzman, A. and Bottorf, J. 2012. Can we move beyond burden and burnout to support the health and wellness of family caregivers to persons with dementia? Evidence from British Columbia, Canada. *Health and Social Care in the Community*, **20**, 01,103-12.

Mead G H 1972. *Espíritu, Persona y Sociedad*. [Mind, Self and Society] Paidós, Buenos Aires, Argentina. [Translation Florial Mazía].

McMunn, A., Nazroo, J., Wahrendorf, M., Breeze, E., and Zaninotto, P. 2009. Participation in socially productive activities, reciprocity and well being in later life: baseline results in England. *Ageing & Society*, **29**, 05, 765-82.

Miura, H., Arai Y., and Yamasaki K. 2005. Feelings of burden and health-related quality of life among family caregivers looking after the impaired elderly. *Psychiatry and Clinical Neurosciences*, **59**, 05, 551-5.

Mora, E. and León Medina, F. J. 2011. La globalización del cuidado y sus cadenas: un estudio de caso.[The globalization of care and its chains: A case study]. *Psicoperspectivas*, **10**, 02, 109-33.

Morse, J. 1989. Strategies for sampling. In Morse, J. (ed.), *Qualitative Nursing Research. A contemporary dialogue*. Aspen, Rockville, Maryland, 117-132.

Negy, C., Schwartz, S. and Reig-Ferrer, A. 2009. Violated expectations and acculturative stress among US Hispanic Immigrants. *Cultural diversity & Ethnic Minority Psychology*, **15**, 3, 255-64.

Nolan, M., Grant, G. and Keady, J. 1996. *Understanding Family Care. A Multidimensional Model of Caring and Coping*. Open University Press, Buckingham, UK.

Parella-Rubio, S. 2003. *Mujer inmigrante y trabajadora: la triple discriminación*. [Migrant woman and worker: a triple discrimination] Barcelona, Anthropos.

Plá-Juliá, I., Banyuls i Llopis, J., Cano-Cano, E., Martí-Gual, A., Pítxer i Campos, J.V., Poveda-Rosa M.M., Sánchez-Velasco A., Ventura-Franch, A., and Bartual-García M. 2007. *Informalidad del empleo y la precariedad laboral de las empleadas del hogar*. [Informal employment and precarious labour of domestic workers] Universidad de Valencia. Available at http://www.inmujer.migualdad.es/mujer/mujeres/estud_inves/658.pdf [Accessed July 7, 2007]

Roe, B., Whattam, M., Young, H., and Dimond, M. 2001 a. Elders' Needs and Experiences of Receiving Formal and Informal Care for their Activities of Daily Living. *Journal of Clinical Nursing*, **10**, 03, 389-97.

Roe, B., Whattam, M., Young, H. and Dimond, M. 2001 b. Elders' Perceptions of Formal and Informal Care: Aspects of Getting and Receiving Help for Activities of Daily Living. *Journal of Clinical Nursing*, **10**, 03, 398-405.

Robinson, A., Lea, E., Hemmings, L. Vosper, G., McCann, D., Weeding, F. and Rumble, R. 2012. Seeking help: issues around the use of day respite care for carers of people with dementia. *Ageing & Society*, **32**, 02, 196-218.

Robles-Silva L. 2007. *La invisibilidad de los cuidados a los enfermos crónicos*. [The invisibility of caring for chronic patients]. Universidad de Guadalajara, Guadalajara, México.

Rodríguez-Rodríguez, V., Martín-Coppola, E., Marcu, S., Ramos-Espina, S., Rojo-Pérez, F., Fernández-Mayoralas-Fernández, G., Lardiés-Bosque, R. and Rogero-García, J. 2010. *Inmigración y cuidados de mayores en los hogares de la comunidad de Madrid. Informe 102 [Migration and care of old persons in their homes in Madrid Region. Report 102]* Portal Mayores, Madrid, Spain.

Salazar-Parreñas, R. 2001. *Servants of globalization. Women, migration and domestic work*. Stanford University Press, Stanford, California.

Salin, S., Kaunonen, M. and Ästedt-Kurki, P. 2009. Informal carers of older family members: how they manage and what support they receive from respite care. *Journal of Clinical Nursing*, **18**, 04, 492-501.

Shaw C., McNamara R., Abrams K., Cannings-John R., Hood K., Longo M., Myles S., O'Mahony S., Roe B. and Williams K. 2009. Systematic review of respite care in the frail elderly. *Health Technology Assessment*, **13**, 20, 1-246.

Shim, B., Landerman, L.R. and Davis, L.L.2011. Correlates of care relationship mutuality among carers of people with Alzheimer's and Parkinson's Disease. *Journal of Advanced Nursing*, **67**, 08,1729-38.

Strauss, A. L.1987. *Qualitative Analysis for Social Scientists*. Cambridge University Press, Cambridge, USA.

Tolkacheva, N., Broese van Groenou, M., De Boer, A. and Van Tilburg, T. 2011. The impact of informal care-giving networks on adult children's care-giver burden. *Ageing & Society*, **31**, 01, 34-51.

Upton, N. and Reed, V. 2005. Caregivers coping in Dementing Illness-Implications for short-term respite care. *The International Journal of Psychiatric Research*, **10**, 03, 1180-96.

Van Der Geest, S., Mul, A. and Vermeulen, H. 2004. Linkages between migration and the care of frail older people: observations from Greece, Ghana and The Netherlands. *Ageing & Society*, **24**, 03, 431 – 450.

Vicente, T.L. and Setién, M.L. 2005. Modelos migratorios femeninos.[Feminine Migration Models] In González Ferreras, J. and Setién, M.L. (eds). *Diversidad*

migratoria. Distintos protagonistas, diferentes contextos [Migration diversity. Different actors, different contexts]. Universidad de Deusto, Bilbao, Spain, 15-39.

Wilding, R. 2006. 'Virtual' intimacies? Families communicating across transnational contexts. *Global networks*, **6**, 02, 125-42.

Wilding, R and Baldassar, L. 2009. Transnational family-work balance: Experiences of Australian migrants caring for ageing parents and young children across distance and borders. *Journal of Family Studies*, **15**, 02, 177-87.

Zechner, M. 2008. Care of older persons in transnational settings. *Journal of Aging Studies*, **22**, 01, 32-44

Table 1. Participants' characteristics

	Family caregivers		Migrant caregivers	
	N=23		N =17	
Age	< 40	1	20-29	1
	40-50	4	30-39	12
	51-60	12	40-49	3
	61-70	3	> 50	1
	> 70	3		
Nationality	Spanish		Ecuadorian	3
			Chilean	5
			Paraguayan	6
			Other	3
Education	No studies	3	Primary	6
	Primary	11	Secondary	7
	Secondary	4	University	2
	Vocational	3		
	University	2		
Residence	Co reside/living with			15
	Live separately			8
Kinship	Daughters			16
	Daughters in law			2
	Wives			4
	Niece			1
Care giving situation	Solo			17

Family and migrant caregiver' relief of burden

	On a rota basis	6		
	Caring for two relatives at the same time	4		

Years as care giver	1-5 years	14	< 1 year	1
	6-11 years	7	1-5 years	15
	>12 years	2	> 6 years	1

Table 2: Findings contrasted

Participants	Family Caregivers	Migrant caregivers
Category: General strategy to gain rest	Taking leave from the life of care giving	Turning to one's own world
Subcategory: Tactics to achieve rest	Connecting with one's own life - distancing Building moments of life in common Keeping in touch with care giving.	Virtual outings, Going to a private place Making those they care for their own Deciding to go home.

Box 1. Guide for interview-Migrant caregivers

Perhaps it is inappropriate to discuss resting in your present situation, but I wonder about the ways that people like you manage to have some respite from caring while caring for a dependent person. I would like, then, to hear about the things you prefer to do to regain strength or to rest. I am interested in your own experience.

-Perhaps we could start by you telling me the meaning that rest has for you in your situation.

-What things help you to rest?

-What do you do to rest from caring?

-Could you tell me about a situation in which you manage to take a rest (use own terms to address rest such as “recharge my batteries”, “recover”) from caring?

-Could you tell me of an instance when you needed a rest but could not get it?

Pront questions:

Could you give me an example?

Are there other ways of doing it? Or do you do it in other ways?

Happens always in that way? Does it changes? How?

Which difficulties you face?

Is there any thing you would like to add?

Box 2. Guide for interview-Family caregivers

As we discussed, I am interested in care giving for a person like your (here address kinship) in particular I wonder about the relief of burden in care giving. I understand that care giving is an arduous work that can wear out people and that tiredness is a common experience in home care giving.

-Could you tell me about the experience of caring for your relative (insert name of kinship)

-I would like to know about how your rest:

What things help you to rest?

What do you do to rest from caring?

Have you ever felt relief or rest? Could you tell me what happen? What does mean to you?

-Could you tell me about a situation in which you manage to take a rest (use own terms to address rest such as “recharge my batteries”, “recover”) from caring?

-Could you tell me of an instance when you would like to have a rest but could not get it?

Pront questions:

Could you give me an example?

Are there other ways of doing it? Or do you do it in other ways?

Happens always in that way? Does it changes? How?

Which difficulties you face?

Is there any thing you would like to add?

¹ The *locutorio* is where immigrants can make very cheap calls using public telephones, contact their families over the internet and send them money,