“Multicultural Adult Foster Care: An Oregon Case Study”

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Abstract

This study is an analysis of an immigrant Romanian family that operates an adult foster care home in a well-established community based health system in Portland, Oregon. The study utilizes categories of elder health and satisfaction identified by elders’ themselves, and include: a. engaged interaction, b. mutual satisfaction in relationships, c. ritual and, d. the reduction of social distance. Little research has been done from the caregivers’ standpoints. In addition to the opportunity to reveal the construction of a particular form of immigrant assimilated knowledge, this study also has the potential to contribute to sociological and public philosophy and policy research aimed at supporting the success of adult foster care homes more broadly.

Key Words: Adult Foster Care / Immigrant Experience / Elder Care
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“And, you know, Romanian people take care of...They took care of my mom, or took care of my uncle, or my aunt. So like I know Romanians, they’re good caregivers. Or, you know, I hear that a lot (Amy).”

How do immigrant, assimilated experiences of care contribute to and determine the health of elderly clients? Existing research has shown that Oregon's development of adult foster care homes between 1975 and 1987 achieved multiple and progressive steps in setting up alternative support services and living options for the elderly. These options were predominantly community-based when coupled with the adoption of federally funded Medicare and Medicaid healthcare system for the elderly. I examine the experiences of members of an immigrant Romanian family that became licensed to own and operate an adult foster care home since 2001, within the context of a well-established community based health system in Portland, Oregon.

The objective of this project is to foster and acknowledge the medical and sociological care-giving motivations, selective interests, and goals of this family from within a feminist philosophical tradition. The goal has been to look at a process and the meanings individuals attribute to their given social situations (Hesse-Biber). This study is not to make generalizations about the benefits of adult foster care homes, but to understand how these kinds of caregivers experience their lives in relation to the people with whom they work and live. They have rarely been included in research discussions and need to become part of more accurate feminist practices.
By conducting in-depth interviews of the caregiving family that is the focus of my case study, I investigate the immigrant family’s contributions to elder care, such as how the care home operates, how the giver and client negotiate intimate care, stereotypes of Romanian immigrants, and the different roles each member of the family plays in client care. This is a preliminary case study for a broader study of adult foster care homes. A case study offers insight into the relational components of human care that can be brought to light more effectively in a small setting. Such detail lends credibility to a unique standpoint. In addition to the opportunity to reveal the construction of a particular form of immigrant assimilated knowledge, this study also has the potential to contribute to sociological and public philosophy and policy research aimed at supporting the success of adult foster care homes in Oregon more broadly. It is for the benefit of those doing research as well as for those acting professionally in the field, for the lay public, and community and governmental policy makers.

The case study utilizes four categories of analysis identified by elders’ themselves, from previous research (Newman and Sherwin). These dimensions have been identified as fostering elder satisfaction and good health. They are: a. engaged interaction, b. mutual satisfaction in relationships, c. ritual and, d. the reduction of social distance. Since little research has been done from the caregivers’ standpoints as to how these issues contribute to the health of elderly clients, this study develops theory that should compliment other work done with elders’ experiential analyses, in order to have a more accurate and more complete understanding of how critical geriatric theory and research relates to practice.
In the first section of this paper I review the history of adult foster care nationally and focus in on Oregon in particular. I also give the basis for the feminist analysis I use in interpreting the data of the case study. In the second part of the paper, I talk specifically about the data in my study and analyze it within regards to the four dimensions of care identified as important to the elderly. The narrative excerpts help us understand what makes family members and clients feel close to each other. Since the four categories of analysis are indicative of client measures of satisfaction, I use these categories to authenticate the caregivers’ motivations and actions as convincing expressions of rational, and trustworthy knowledge that contributes to client health.

**Historical Context**

Before World War II, care for the elderly outside their own residences took place for the most part in private care homes—locations that were used primarily for the mentally ill (Achenbaum, A. 1978; Baltes, M. M. 1996). Care in these small, privately run homes had its limitations, from a lack of reliable transport to access medical care to inadequate medical knowledge and skills, which often led to an inability to provide care, triage problems, and obtain needed assistance. The post-WWII industrialization of elder health resulted in the widespread creation of privately and federally funded nursing homes, which provided comprehensive care in an institutional setting. The nursing home removed the elderly from relative isolation, making visible the viability and vitality of those who were not considered mentally ill, but rather just physically unable to care for themselves. The nursing home became the centralized location where the elderly could receive a range of medical services not subject to the financial and feasibility limitations of smaller run homes. Nursing homes were regulated so that all residents had single-
location access to triage and self-care, while having their individual medical needs provided for as well. The development of the nursing home industry was coupled with the adoption of a federally funded Medicare and Medicaid healthcare system for the elderly, which allowed for the expansion of elder care for much of the second half of the 20th century.

The nursing home industry did have its critics. Many elderly individuals and their family members felt industrialized within these relatively institutional settings and processes. As a result, many people envisioned using Medicare benefits to supplement alternative elder care outside of an institutional setting.

The state of Oregon has a long history of small-business entrepreneurship, and the state has now established a reputation for creating successful, family-oriented adult foster care homes that feature skilled and knowledgeable personalized care. These small, family-run businesses have generated improvements in elder care beyond transforming the traditional image of an isolated, shut-away home: these enterprises are staffed by individuals with a strong inclination to care for the elderly in their own homes, are state-monitored and financially supported by expanded Medicare coverage and through private pay channels, and are considered solid alternatives to institutional settings for medical care.

**Feminist Theory (Critical Gerontology)**

In most case studies, knowledge is sourced through the observations and claims of medical experts: physicians, registered nurses, certified doctor assistants and a large variety of professional therapists. Knowledge that emerges directly from caregivers within foster care settings is not traditionally considered expert knowledge. In my study I
use traditional feminist methodology, which recognizes that knowledge is not only sourced from positions of power and prestige, but from skilled standpoints such as the observations of caregivers in the foster care settings I research. I consider the caregivers observations as legitimate sources of knowledge, and I invite the subjective experiences of the caregivers who engage in the subtleties of experiential care, the minutiae of which are often overlooked.

In many studies, reports from caregivers are recognized only as passive knowledge, having value only from an observational point of view: caregivers report to professionals what they objectively observe, without interpretation. (Somewhat counter intuitively, these voices are also considered to be subjectively biased and prejudicial. However, the subjective nature of knowledge has been recognized by feminist epistemologists to both contribute to and determine what counts as knowledge, what counts as evidence of knowledge, and who gets to know.) The feminist methodology used in this study posits that all observational information, (including professional information) is the product of active selective observational interests; as such, caregiver observations are active interpretations. Knowledge is defined as information that has been filtered through a variety of lenses of socially constructed notions of skill and intelligence; traditionally, professional information has been afforded a higher level of respect and credulity (Code, 1995). A feminist analysis broadens that notion of knowledge in recognizing that all knowledge is partial and interpreted. In the end, the sum of partial meanings granted by varying and selective interests, intelligence, and skills contribute to more complete knowledge. By granting caregiver observations an active
voice, my premise allows their voices to contribute to a more complete and accurate professional observation.

The well being of elderly clients relies on the quality of care they receive on a daily basis. All adult foster care homes are not presumed to provide better care than alternative settings. The overall picture of health care depends on many factors, including a broad assessment of what kinds of care particular clients need. However, I do propose that, for a set of clients appropriately placed within a recognized well run adult foster care home, the kinds of information the caregivers provide is not limited to simple observations that act solely as a conduit for someone else’s knowledge expression. Instead, these caregivers themselves serve as a source of knowledge—knowledge that provides interpretive information, laden with meanings that are essential to the thriving of an elderly population that they serve.¹

**Oregon and Previous Elder Care Studies**

At the outset, nursing home care was not only envisioned as a centralized location to administer uniform care, but was considered the gold standard of care for the elderly as the obvious, reasonable, and preferable choice—away from the seclusion and inept or below-standard medical care of the sheltered and isolated homes of the early 20th century. As time went on, elders developed a desire to have alternatives to nursing home care. Some of the factors that led to this desire were described in a study in late 1970s New York, where Newman and Sherwin (1979) devised four, dimensional variables to measure elders’ satisfaction with their care. They took shelter home research from community care of the elderly and family care of the mentally ill, and envisioned the possibility of foster-family care. Using concepts from research on factors that make
family members feel close to each other, Newman and Sherwin outlined four dimensions for consideration of satisfaction:

1. interaction,
2. mutual satisfaction in relationships,
3. ritual, and
4. reduction of social distance.

The far-reaching impact of this study and others like it made elder care public health issues more visible, and created a broad philosophical change. Instead of the “continuum of care” model prevalent in nursing homes, in which elders literally move to the next level of a care facility wing, a philosophy of “ageing in place” emerged, in which elders change their “service package” when there is an increased need.

Questions remained regarding cost issues, and also the impact of an increased number of adult foster care residents on the actual number of nursing home residents. One Oregon study in the late 1990s found that some private pay residents were willing to pay much more for perceived better access to medical care in adult foster care homes, but that some Medicare consumers would not have access to adult foster care beds because of a higher cost of care (Nyman, et al. 1997). In addition, policies designed to increase either the number of private or Medicare residents in adult foster care home were found to result in fewer nursing home residents, although not a one-for-one substitution.

Seniors began to draw attention to the disadvantages of having comprehensive care when they didn’t need it in nursing homes, the prohibitive additional expense of leaving their homes and moving into nursing home care, and that the lifestyle and consequences of institutional care was in many cases inhumane. Organizations and
individuals who were inclined lobbied on behalf of seniors and were alarmed by deficiencies of state and federal assistance for elder care particularly for low-income seniors as well as realized increasingly that the only assistance in their own care as well as others’ care was to enter a nursing home in most of the country.

In Oregon, “seniors of intelligence, means and stamina” became activists (Oregon Senior Forums, 2013). Change played out in a “long term care service network that addressed the values of independence, dignity, privacy, and choice” (Dietsche, 1996). This sentiment early on became policy in the Oregon 1981 legislature’s creation of the Senior and Disabled Services Division of the Oregon Department of Human Resources. Its formation “emphasized that the network was to support the belief that frail elderly and persons with physical disabilities wanted long-term care services in their own home if possible, in substitute homes if they no longer had a home or could not remain any longer in their own home, and only as a last resort in nursing facilities or other institutions” (Dietsch, 1996). The innovative law also required that savings from a reduction of nursing home populations were to be reinvested into community-based care to help with any higher costs of foster home care. Such a policy may have contributed to the Nyberg study that adult foster care populations could be increasingly substitutable for nursing home populations although I could not confirm that. I suggest at least that such a policy could have contributed to a rise in an adult foster care populations, The focus of nursing home care evolved for acute, short-term convalescent, rehabilitative and end-of-life care, none of which would necessarily been attractive to people seeking long term care.
As a result, between 1975 and 1987 Oregon made significant progress in setting up alternative support services and living options that were predominantly community-based:

- Oregon Project Independence provided in-home services and data to help seniors avoid nursing homes;
- The state obtained a federal Medicare/Medicaid waiver to use federal funds for adult foster care settings and in-home care;
- Oregon codified an independence, dignity, and choice policy that removed many of the traditional restrictions for elder care services;
- A single agency was created to oversee policy, budget, eligibility of long-term-care, standardized assessments, and pre-admission screening;
- the state supported outreach and creation of home and community-based resources; and
- Oregon passed a law that allowed RN supervision and training of nonregistered nurses to provide certain services (Oregon Senior Forums, 2013).

Adult foster care environments have experienced an upsurge in popularity: the number of residents supported by Medicare waivers grew by 176 per cent between 1995 and 2002 (Kitchener, et al. cited in Hendrick, 2009), and a survey from Mollica and Johnson-Lamarche (2005) found that 36 states have been approved to cover community-based residential services using a state plan and Medicare waivers. However, both positive and negative traits have been identified in surveys of these environments. On the positive side, adult foster care homes are more home-like, maintain a less institutional atmosphere, cost less than skilled nursing care, are more feasible in rural areas, and are
independently owned. However, Susan Hendrick’s analysis in 2009 noted that potential trade-offs include limited services, privacy, and resident autonomy compared to larger facilities (34). This observation was shared in studies from other states where state officials support people staying in their own homes, including Hawaii, Maryland, and Wisconsin (Weiner 2001; Alecxih 2002).

Worldwide, most elderly people prefer long-term care in their own homes; however, some do not—particularly if they view themselves as a burden they would rather not impose on those whom they love (Krothe, 217–26). Families that do provide their elderly members with long-term care meet with many challenges beyond the financial. U.S. family caregivers report a wide range of positive and negative feelings about their service, such as being loved (96 per cent), proud (84 per cent), worried (53 per cent), frustrated (37 per cent), sad or depressed (28 per cent), and overwhelmed (19 per cent) (Wurman, 236). In general, family members in the U.S. tend to negotiate among themselves to determine who will be the primary caregiver for an elderly relative. Factors that play a role in making such a determination are family history (24 per cent, proximity to elderly relative(s) (21 per cent), no competing obligations (15 per cent), and access to resources (15 per cent) (Albert and Cattell 1994: 132–3). If home-based, long-term care is an elderly person’s preference, he or she may not be able to secure it if family members or friends are unable or unwilling to provide it. Therefore, a considerable number of elderly people leave their home and move into an alternative residential setting that may or may not be government subsidized. (3)

**Gender**
Many analyses study elder women specifically, focusing on the health impacts of the increasing isolation of growing old in America (Richman, 1977)—financially, socially, medically (Seeman, 1996), and widowed or not (Krause, 1987, 1994; Kane 2005). However, women’s voices oftentimes go unheard in the healthcare field—not only the voices of ageing women themselves, but those elders’ caregivers, who most often are themselves women (whether family members or independent caregivers).

The term “feminization of ageing” has been coined to describe the increasing numbers of women in the older population (Mujahid, 2008; Davidson, 1041), and it is becoming recognized that age must not be the only consideration taken by policymakers and the health system. A gendered approach must be adopted that considers the unique positions of older women—not only in terms of differences in biology, but in terms of the skewed social, political, and cultural constructs and roles given to women and that women accept. This approach is necessary in improving the health of older women in that gender-neutral policies often still create harm or bias against women (Parrott, 2002; Davidson, 1040). “Although policy makers globally are attuned to the needs of the ageing population, the focus on the needs of women specifically is more confined to nongovernment organizations, rather than peak government bodies, and as a consequence the unique needs of women are less visible in population planning and policy (Mendis, Puska, & Norrving, 2011).” Relatively little analysis has been offered on the experiences of older women as opposed to the larger category of “the elderly.” The percentage of women outliving their spouses and living into old age far surpasses the percentage of men with the same experience (This pattern continues in spite of the new mantra “70’s are the new 50’s” with regards to increased elder activity (Beal, C. 2006)).
Entrenched social and health inequalities, particularly those related to employment and salary, can impact older women (Beaglehole et al., 2007)—both from the perspective of an ageing population of women needing care, and the caregivers themselves. The caregiving role of women often limits workforce participation, contributing to poorer health in older age (Byles, Feldman, & Mishra, 1999; Lowe et al., 2008; Navaie-Waliser, Spriggs, & Feldman, 2002; Parrott, 2002). Furthermore, older women may not have been in the workforce long enough to accrue adequate support in the form of retirement or superannuation savings (Davidson, 1035). On average, U.S. female caregivers provide assistance for one to four years, but it is not unusual for a U.S. female caregiver to provide care for a family member for five or more years (Stone, 616–26). Because these women often find that family care work takes 22.9 or more hours out of their week (Barrett, 8), many U.S. female caregivers give up or substantially reduce paid work outside the home (Barrett, 8).

**Case Study**

My strategy was to conduct in-depth interviews of adult foster care home caregivers in the same family-run business in the Portland, Oregon metro area. I am familiar with this particular adult foster care home and well acquainted with all the family caregivers since my mother was intermittently under their care for two years, 2010-2012. I have maintained contact with the family since this time. The family members names have been changed to protect their privacy.²

The family consists of a husband and wife, immigrant, Romanian couple who had tried in the 1980’s to escape the dictatorship under Ceausescu, but who were unable to
get passports and visas until two years after the dictator died in 1989. They made the heart wrenching decision to leave their two children ages five and ten behind, as passports for an entire family were impossible to obtain, given the pervasive suspicion of citizen defection. After staying and working for relatives in southern California, the two found work in an adult foster care home in Oregon from 1992 through 2000. They have owned their own adult foster care home in Oregon since 2001. Their children were allowed to join them at this point, at the ages of 15 and 20.

The caregivers I focus on are paid women. Nevertheless, I propose they may be uniquely sensitive to the manner in which they give care due to the fact that American culture expects women in particular to serve as caregivers of the elderly when possible (Stone), and that women in general develop caregiving skills as a result. In addition, my particular group of caregivers comes from a culture where these gendered roles are even more strongly expected and reinforced by what may appear to be essentialist characteristics of femaleness. Because of this, the caregivers in my study are expected not only to care for their clients, but also to care about them. A caregiver I’ll call Amy states:

“I think it has to do with the culture. It’s the most natural thing to us. So what do you do when you move in a country that, you know, either you speak English or not, and start from ground zero with the family? You’re going to do whatever you think is the most natural to you. . . . And it’s like basically home away from home, because that’s what you did back home.

Women are the basically kind of caregivers. It’s a culture where the mother takes care of the home, cooking and cleaning and taking the kids to school. And dad is
the provider. So basically, in a home care environment you work together as husband and wife in the home, but basically the female does the cooking and more of the work. And the male would do the outside work of taking care of the home, make sure nothing breaks, everything is in order.”

An older women’s health is affected and in many cases burdened by a number of other factors. Traditionally the focus of women’s health has been reproductive health or maternal health, with a lack of emphasis on chronic conditions (Raymond et al., 2005). This means that chronic care facilities may not be gender appropriate for women or may not have staff that is trained in the specific needs of older women and their unique presentation of symptoms (Day, 2003). This is reflected by the fact that women, particularly in older ages, are often underrepresented in clinical trials and research. This underrepresentation has hindered the development of sex-specific treatment and policy guidelines (Parrott, 2002; World Health Organization, 2009; Davidson, 2013). In spite of the absence of sex-specific treatment protocol, the caregivers in this case study often offer sex-specific care. In the following case, the caregiver treats her client as she might her own grandmother:

“I love helping people. I love giving a chance at a better situation, or better environment, or a home environment that they cannot have at home. And I know I can offer that. That’s what motivates me. It’s just, you connect with people and say, you are just like my grandma: I could take you home. And that’s where it kind of, it goes from there. I mean, I like all my clients but it’s such an amazing feeling when you get that feeling like it feels like I’ve known you my whole life (Amy).”
In addition, because an adult foster-care setting features close observations and interpretations of the behavior and symptoms of elder women, a caregiver might be in the position of interpreting, for example, signs of confusion as evidence of an urinary tract infection. Such observations and interpretations may help compensate for the absence of broad sex-specific treatment and policy guidelines.

“I live with this person every day. This is what I’ve noticed, what, you know . . . what they need or what we . . . Because there’s always a pattern, and with elderly people it follows the same pattern when it comes to illness or sickness. Or if they get sick it’s always, this, this, or that. Like a UTI, urinary tract infection or, okay, they have a lung infection. Or, you know, you see the same symptoms all the time. And you try . . . So because we see it a lot, we think that it might be this (Amy).”

In order to meet the needs of the elderly, health and social service interventions must take account of gender realities from both economic and social perspectives (Davidson, 1037). Many older women, even those in generally good health, will require both an increase in instrumental and social support. Health professionals must understand the broader considerations; for example, the caregivers also see their role as supporting the client’s extended family.

“Yes. I mean, we’re there for each other. And we’re there as a family. And we’re there to remind them it’s, you know, it could be worse. And we’re here to make it better. We’re here…we’re a team. We’re going to work together. And it’s funny because we had one patient once where she was really, her mind wasn’t working well at all. She was not communicating and not, you know, not responding to her
And it was Christmas Day. Going to make me cry. [Emotional] Christmas Day we dressed her up. And we dressed her in red. And we took pictures by the tree, and she started talking about her children. And we re[c]ordered her and sent that to her family. . . . She just kind of like smiled, and she was excited. She loved the tree and the lights, like it was [Name]. I’m like, oh my god [Name], wait until your family sees this. Her family started like, all of her kids starting crying. They all like, it was the best gift they could ever receive from their mother is having her smile in that picture and having her being just her old self. . . . Christmas Day. I’m like, and that’s…I think that’s the most amazing thing in life. Because nothing can buy that. Nothing can give you that unless you have hope, you see positive of (Amy)”.

Providing care that enables independence and dignity that the elderly state they want is an important consideration (Byles, 1998).

You always…You never give up. No matter how bad a person can be you always treat them and act towards them like they’re there completely. Sometimes it might drive you crazy, because mentally it takes a toll on you too. But knowing that you don’t give up, there’s that chance that somebody they might just come back and say hello, I’m here, I’m good. Life is good, you know (Amy).”

Enabling equitable access to clients and their families is of critical importance (Davidson, 1037):

“And I know their history. I know their children. I know their pictures. I look at ….I mean, I have clients that live in our home for years; seven years, five years,
three years. So you form a bond, a relationship that is just like, you know all their extended family. You call them. You have their phone numbers in your cell phone. So, you know, it’s just….And even when they come to visit, we always tell them don’t ring the bell, just come in. Or if you ring the bell so we know if we’re in the back and we don’t hear you come in we know someone is in. But we’re not like the door’s locked and you better call before you come to visit your mom. No, just come in. We’re here. We’re not moving. We’re not going anywhere. Just come over. Someone is going to be in the house for sure. One of us. So, you know, it’s like just going home. You don’t have to make an appointment or call can I come visit my mom or is, you know, available today, or you know. Just come on in. We’re here (Amy).”

And fiercely independent women have needs that go beyond a traditional medical response and include issues around support, networks, and resources (Feldman et al., 2002), thus minimizing the potential for exploitation as well:

“Oh, it gives me goose bumps thinking of your mom. In a good way. . . . She is just like, oh my, she was just amazing, and fun, and creative, and challenging. And I love that. I absolutely love that because I’ve never met someone so challenging. But I said, we can do this. We can make this work. . . . It takes a toll on you mentally. Because they, you know, can’t understand or can’t…you know. We don’t take it personal at all because they don’t do that on purpose, or to hurt me, or to get me upset. But you’re only human and sometimes they think you’re the bad guy. And you try so much to show them that you’re not, or try to work with what you have. And no matter what you do you’re still the bad guy in that
situation. So you have to kind of let go and have someone else come in and save the situation. Because there are clients that, you know, in a certain situation that you can’t get through to them so someone else has to (Amy).”

More often than not, that someone else consists of another family member.

**Four Categories of Analysis**

**Engaged Interaction:** The family’s daughter, Amy and son, Gabe arrived in America in 2001, not knowing the customs or language of American culture. Amy, age 28 at the time of her interview, recalls that she immediately began to help with the clients in the home. She compared caring for the clients with caring for her own grandmother back in Romania.

“Yes, at first I was kind of standoffish because I’ve never seen that before. And I’ve never seen elderly people with mental, like disabilities that I wasn’t used to. I’ve never seen people with dementia, or met people with dementia. Or Alzheimer’s, or Schizophrenia. I knew about them, but to kind of be…kind of thrown in it, it’s kind of like, wow, this is weird! . . . . I did help, but it was a shock at first. It was a shock, but I got over it quick. Because then it kind of like, okay, this is like take care of my grandma. Okay, I can do this. This is not … It’s not so awkward (Amy).”

Amy’s efforts to change herself and not the client is a unique perspective gained only from having a particular standpoint where the caregiver is enhancing the client’s life rather than using the power differential between the caregiver and a dependent client, to
the benefit or ease of the caregiver. Such a standpoint reduces the risk of exploitation. Vi, Amy’s mother, recalls Amy’s efforts to assimilate and maintain her sense of the importance of relationship:

“When they moved in 2000 … As soon as they step [sic] in this house they helped me. My daughter slept with one of my clients. She just went and slept with her. She just loved, her name was [name] And, she slept with [name] Of course, [name] was wearing Depends and the next day my daughter smell like [name], because she wet the bed. But she didn’t care. She just went to sleep with her. . . . Being the oldest one was like grandma for her (Vi).”

Amy reduced social distance with her client literally and figuratively. Her interactions reinforced the value of personal engagement whose benefit in not only to perform the required care of the clients, but to emotionally engage with what the clients need, want and capable of sharing themselves. Her manner of interaction not only limited potential harm given her limited knowledge of English, but performed in ways that benefited the clients overall.

“I would do at first household chores, like help her with the cleaning, or help someone go to the restroom. Or feed someone. Try to calm someone down, or you know, just … Or have a conversation with one of them. Whatever I could come up with, because I didn’t speak very well English. I mean, at all, just a few words. But just to keep them company, someone smiling at them. . . . And saying hi, how are you, or do you need your feet rubbed or . . . do their nails. I would do
their nails. . . . Or even their makeup. I did their make up and hair. I liked that. . . .

Curl their hair. I did that quite often. It was fun (Amy).”

Amy’s efforts to go beyond required care ensured that her engagement was for the benefit of the clients. She did not assume that she knew what to do. She built her knowledge over time in her respectful interactions and attributes the development of her current skills particularly to those interactions and not from being told what to do. Now, at age 28, Amy reflects on her current ability to interact with clients:

“I wouldn’t consider myself an expert. No, I’m just learning everyday new things. You always learn. So I don’t think I’m expert, but I know how to deal with the situation if you put me…throw me in it. I’m not afraid, and I’m not…you know, I know what to do (Amy).”

“So you’ve learned how to deal with lots of different personalities (interviewer).”

“Yes. And that is fun. Because you don’t…it’s you don’t change…You don’t learn to change the person. You learn to change yourself, to challenge yourself to think different and act differently so you comfort the other person. So I think that’s the fun part of you’re not trying to change someone, you’re trying to change yourself to better someone else. . . . Even when their [sic] mentally ill and they don’t, you know, they don’t have control over that. They don’t know they’re doing it, you know, so . . . (Amy).”

Perhaps shadowing her mother’s skills, Amy developed a rapport that recognizes the client’s vulnerability that puts the caregiver on the same level playing field as the client, which deemphasizes their dependence:
“And, also makes me happy when I can help people, when [sic] see them being well taken care of and when I see them like come to me they tell me, I love you, you are wonderful. You know, when I see them happy and thankful for what I’m doing (Vi).”

Engaged interaction allows the caregiver to learn from the client; allow for the needs to emerge from the client instead of imposing assumptions of care; requires the caregiver to adapt to the client and figure out ways of interacting that is to the benefit of the client. This form of interaction could be considered somewhat akin to dimensions of Community Based Participatory Research (Maguire).

**Mutual Satisfaction in Relationships:** The family’s motivation is create to a unique home setting to care for the elderly.

“Well, our first…I think when you walk in our home, we don’t consider that a facility. That’s our home. One, we live there, and two, look around it, it’s nothing like a facility. It’s just like a regular house with rooms. And it follows some regulations that, you know, to look like a facility, but it doesn’t really. It’s more of a home environment. We home cook and get organic stuff. And we get our eggs from the farm and, you know, it’s just. That’s our goal. Our goal is not to have a facility, but have a home environment for people that need a little more a home, a second home away from home. If they cannot live at home, they can live with us and still feel like this is a home (Amy).”

They believe that creating a home setting increases trust.
“...think the advantage of having a foster home with just five clients, you do a lot of one-on-one care. And you’re more...You get to know them better. And you get to connect and form a relationship than if you are in a nursing home where you might have two nurses taking care of ten patients in one day. So in that scenario it’s more basic things that they need than just more a relationship.

...But I’m sure relationships form no matter what and stuff, but I think having more, a smaller group to take care of and having three caregivers in the house you get to really get to know them and kind of become your family. You see them...You have the same caregivers every day. As in a bigger facility you always have your rotation. You have different caregivers coming in. So you never...you lose that, you know, connection, and trust and get to know them so that can really...And that’s very important when it comes to elderly people, because they experience a lot of fear and they need someone that they can trust and fully put their...They put their feelings out there, their fears, their insecurities (Amy).”

Amy creates rapport with her clients as an extension of her own everyday life. Given the close relationships the caregivers can develop with their clients, it is even possible to observe the client’s flexibility in their own lives:

“Basically their independence, because they can’t be independent anymore. And they need a person that they can trust for them to do that, say I can’t take care of myself, so I have to put my trust in you. And that’s very hard when you’re very independent to give up who you are in a way. Because you have to change. Because your body or your mind is changing, so you have to work with that.
that’s very important for them to trust you and to see you as a friend; not necessarily a caregiver, as a friend that’s there to help you (Amy).”

Amy’s role is to be a sort of chameleon—which allows the clients to make sense of their own environment, to give meaning to their own experiences—rather than to impose a structure that the clients must fit into. As Amy attests, both the caregiver and the client must adapt to each other to create a mutual relationship.

**Reduction of Social Distance:** The manner in which clients and caregivers refer to each other is evidence of their particular effort to reduce social distance. The caregivers are referred to by name not function:

“... I don’t remember ever been called a caregiver by any of my patients. They call me, she’s the lady that takes care of me, or she’s the lady that helps me, or by my name” . . . . “Because you form a relationship, and you form a trust. And also feelings for each other. Really do. And I think when that happens then you don’t see that person as kind of a stranger or caregiver. She’s your friend. My friend [Amy] or my friend [Vi]. You know, it’s just kind of natural that way. It comes natural to call me by name (Amy).” And Amy does not call the residents “her clients”. “It’s more of a term, but they’re more like, in our point of view it’s family. Extended family, or it’s just like because they live with us we...I mean, they’re there 24/7 and we’re there 24/7” (Amy).”

When the particular is focused on, individual voices are acknowledged. The elderly, like any other population, do not want to be generalized and assumed to be all the same. They
don’t want to lose control over their bodies; to be medicalized. “As with other systems of inequality, an exploration of age relations must begin by listening to those disadvantaged by them (Calasanti, Slevin & King, 18).” Effective listening reduces social distance and distance can be measured by how the roles are played as well:

“... I mean, it’s if you come off as a professional, then they’re going to treat you like a stranger. If you come off as a friend, you’re just meeting someone, and you’re friendly and you’re outgoing. And you don’t come in talking medical stuff, and diagnosis and all that stuff that nobody wants to talk about. Or you know, it’s just…and medications, and history and all that stuff. You just come in as a friend. I’m here to help you and I’m here to make this fun. And you don’t have to worry about anything else or talk about meds or...And actually, a lot of the kind of medical side of it we don’t even necessarily always talk to the patient in front of them if they don’t want to. We deal with that with the family members so that they don’t have to worry about or feel embarrassed or feel like, okay, my whole history is now unfolding in front of this stranger (Amy).”

“Unlike other hierarchies, in which the privileged rarely become the oppressed, we all face age oppression if we live long enough (Calasanti, 25).” These caregivers do not deny age. Age relations are the center of their caring lives.

“And we only have one or two caregivers that give us days off. And they’re there all the time. We try not to hire more than two or get different people in the home, because they don’t like that. I wouldn’t like that really. So.... Yeah. And they actually look out for you. It’s so amazing. It’s such an amazing relationship. I had
this client where she needed help to be lifted. And she goes, don’t do that. That’s too much. That’s hard work for you. You work too hard. Let me try really hard and we can work together. But don’t do it, I don’t want you to do it. It’s like, well this is…that’s why I’m here. I’m here to help you. I’m here to lift you if we need to lift you. But it’s just, it’s a good feeling, because then you feel that someone cares for you too. You know, it feels…it’s kind of special (Amy).”

Given this family’s approach to locate themselves on the same plane with the person they are working with (Smith 1992), Amy and her mother are able to relate to their clients as family members, as not totally dependent, rather more as a part of a household and not necessarily any different from themselves.

*Ritual:* Ritual and professional expectations are necessarily part of any respected and successful business. Client rituals in this setting can be vital, and can welcome a caregiver into a client’s world. Amy even adjusts her personal rituals to better relate to one particular client:

“... Even like for example, medication. It’s so funny. Like, I have a patient that she doesn’t really like to take meds. And some of them are medications and some of them are vitamins. So the way I make her feel better by taking her meds, I take my vitamins at the same time with her. And say, see, it’s not like, you know, you’re in this alone or I’m drugged up, you know, I have to take meds because I’m older and you don’t because you’re younger. And I go, no, it’s not true. Look at my meds. And, you know, we take them at the same time. And it makes her
feel so much better that it’s not like, okay, I’m not alone in this. She’s doing it too.

So it’s kind of helping each other out (Amy).”

Caregiver and client relationships entail these kinds of shared standpoints. One’s insider status helps to obtain access and rapport within the situation. This rapport also provides the maximum opportunity for the client to be heard and represented. It allows for the possibility of an open dialogue. Likewise, not sharing the same standpoint may allow for the accumulation of knowledge. The diversity among and between experiences, does not interfere with our capacity to build knowledge (Brooks). Each woman’s standpoint may direct our attention to details and features that we might otherwise overlook (Longino).

When Amy interprets client realities from her own lived experience her standpoint creates shared knowledge, particularly in her interactions with professionals who come into the home. Doctors, therapists, hairdressers, and social workers are all on-call as well as scheduled for monthly visits. Doctors may assume that patients’ complaints are due to old age (Quadagno) and question the knowledge base of unskilled caregivers. Amy’s defers to doctors’ opinions, but does not withhold the possibility of her shared knowledge.

“It varies. So it depends on….There’s some doctors that just, they see you just as a caregiver and that’s that. Your opinion, it doesn’t always matter. They go more on the professional side than, okay, I live with this person every day. This is what I’ve noticed, what, you know . . . Yeah, what they need or what we . . . Because there’s always a pattern, and with elderly people it follows the same pattern when it comes to illness or sickness. Or if they get sick it’s always, this, this, or that. Like a UTI, urinary tract infection or, okay, they have a lung infection. Or, you know, you see the same symptoms all the time. And you try… we try not to give
that to the doctor. We kind of work around it. Because they don’t like us as caregivers, not professional to come up with like, okay, I think this is what the reason is for this person being sick this way. And those are the symptoms. So because we see it a lot, we think that it might be this.

Not that this is it, but that this might be one of the options. So we always try to work around that. That’s always . . . We’re very careful about that. And I respect that, because I am not a doctor. I’m just guessing from what I’ve learned over the years. And we have doctors and nurses that we just call up and say, this is what we think it is. We’re very open in the sense that, okay, she might have a UTI. And then they come in and check that and take a urine sample. And it’s in fact, okay, yeah, this is what it is. So, here we go (Amy).”

Amy’s resignation to the needs for professional ritual do not limit her expression. She is determined to provide information that is consistent with professional observations and is evidence of what she values in the reliable experience of her standpoint. The fact that subjective experience is considered by many to be only partial and biased does not work to the disadvantage of her knowledge. All knowledge is partial (Haraway).

Objective knowledge is not knowledge that is value-free. All knowledge comes with a bias that is, a standpoint from which one’s selective interests determine what counts as important; what is not significant; what is observed and what is not observed. Objectivity is about increased accuracy and accountability (Harding) not about foundational, absolute and inherent truth. Knowledge is created not discovered (Dewey). So objectivity entails the augmentation and accumulation of as many partial perspectives
as possible with the goal of achieving a more accurate representation of the reality at hand as well.

Consequently, what Amy proffers to the professional may be biased but the issue of knowledge is not that her knowledge is more biased than the professional’s. Professional knowledge is partial as well. All standpoints offer specialized knowledge to be used in non-prejudicial manners. These standpoints are a kind of specialized knowledge; subjective insights that are vital to the wellbeing of individuals. Some observations may be inaccurate, but subjective knowledge cannot be dismissed on the basis of its partiality.

“I mean, I respect both sides. I have, you know, I’m not a doctor. I didn’t go to medical school, so I understand that. . . . I’m just here to help. Yeah. I’m just here to give you all the information I have so it can help this doctor. My interest, as his interest, is to help my patient. And that’s the info, so . . . (Amy).”

Amy provides her interpreted observations to the professionals as knowledge. The traditional “problem of knowledge” is what can we know? The feminist problem of knowledge is not, what can we know? but, who gets to know and who decides who gets to know? The caregiver’s status as a knowledge provider is only a problem given the interpretations of the content of that knowledge by others. The problem lies with the epistemological status of interpretation. Knowledge can be understood as created rather than always discovered by trained professionals. Knowledge can be understood as an interpretation of what is selectively observed. Perhaps the problem of knowledge has also
to do with education as well as epistemology. How does the professional consider nonprofessional knowledge? Is it less reliable? More incomplete than his or her own?

**Conclusion**

This case study is offered as a look through a keyhole into the lives of a particular set of adult foster caregivers, and augments prior research, which has focused on the professional interpretation of care and on the voices of the elders’ desires and needs. I offer the standpoint of the caregivers as a vital component of knowledge from a feminist perspective. In so doing, I provide a more complete and more accurate picture of health indicators in elders’ lives in adult foster care. I started my research by looking at individual lives—in this case the specific lives of women who are the caregivers. Starting with specific lives is one of the main tenets of feminist research. This method allows a way of pointing to where people live their lives so that “anyone’s experience, however various, could become a beginning-place [for] inquiry (Smith, 1992, 90).” This is not to say that women know better, but because they find themselves in positions of caring, this embodied activity provides insights that serve as interpretations of knowledge, not passive observations for others to interpret.

These caregivers’ experiences also are being used in this study as a mediation between professionals and non-professionals. This serves to highlight the bifurcated consciousness of women as they work in settings less conducive to articulating the knowledge that comes from their activities as well as to understand how power relationships shape although do not determine women’s accounts of their experiences (Smith 1990). Traditional versions of what counts as knowledge and who gets to know
make clear distinctions between the knower and the known. I postulate that the voices of these women caregiver are “resources not contaminants” (Krieger) of knowledge claims.

I have looked not only at individual caregiver knowledge, but have also taken into account the fact that these caregivers are members of the Romanian immigrant community. This methodology recognizes knowledge as beginning with a collective experience—not only because these caregivers are members of the same family, but also because we are also reminded that knowledge is communal (Nelson). What counts as evidence emerges squarely from within a community of interests. We cannot help but notice that the object of investigation depends upon the subject who knows it (Code, 1991). A particular epistemologically relevant community creates a knowing interpretation. So the important part of the investigation into knowledge is both personal and collective, within the individual who is found within a particular community.

I have tried not to naturalize ethnic differences in my research. I have attempted to embody caregiving within a particular immigrant setting that was explained by the caregivers themselves as naturally reinforcing what human beings find most comforting, i.e., caring for family when faced with new and unfamiliar settings. The collective experiences of caregiving are set within the professional formal business setting with accompanying client relations’ rules and regulations. These rituals specify and boundary professional and business responsibilities but do not restrict interaction, mutual engagement, comforting rituals and the reduction of social distance, those elements identified as vital to many elders. It is because these elements are not boundaried by the professional protocol that they are accessible in a direct fashion. The ability of immigrant
families to “world travel” (Lugones) that is, to cultivate an ability to move across social boundaries are central to immigrant experiences and uniquely articulated in this study.

References


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Endnotes

1 Although beyond the scope of this paper, found elsewhere are in-depth discussions of long-term care policy in the U.S., are answers to the question: Should eldercare continue to be relegated as a job that is so unimportant and invisible that it is left in the hands of unpaid family members, low-paid migrant workers, or new immigrants (Glazer, 1990; Glenn, 1992; Tung, 2000; Browne, et.al. 2006)

2 That I was introduced to this particular family by way of my own mother’s care enhances my interest and ability to focus as a researcher on this topic. This research began two years after my professional relationship with this family ended. And, this research draws on the six-year period of time that I as a researcher have focused my attention on the importance of these particular voices in my expertise and scholarship in feminist science studies. The difficult boundaries between research and friendship identify the heightened danger of exploitation or the imbalance of power between the researcher and her interviewees. The interview process has
offered the possibility of a unique interaction with these participants and I have taken care to decrease the possibility of power and authority imbalances that could have negatively affected the interview situation (Hesse-Biber). The caregivers and I shared stories with one another over the care of my own mother, which increased reciprocity and rapport in the interview process and broke down the notions of power and authority invested in my role as the researcher (Hesse-Biber).