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## Family care across diverse cultures: *Re-envisioning* using a transnational lens



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### ABSTRACT

In an increasingly globalized world, the importance of developing a more culturally complex understanding of family care has been clearly identified. This study explored family care across three different cultural groups - Chinese, South Asian, and Latin American - living in a metropolitan, Pacific-West, Canadian city. In-depth qualitative interviews were conducted with 29 family members from one of the three family groups exploring how they practiced 'care' for their aging, often frail, relatives. The importance of conceptualizing family care as a transnational, collective undertaking emerged from the outset as critical for understanding care practices in all three cultural communities. Three themes identified contributed to this conceptualization: the need to broaden the understanding of family care; the centrality of geographic mobility, and the need to rethink the location of aging and consider its relationship to mobility; and the use of technology by extended family networks to facilitate continuity and connection. An over-riding notion of 'flow' or fluid movement, rather than a fixed, static arrangement, emerged as critical for understanding family care. This perspective challenges the dominant approach to studying family care in gerontology that generally conceptualizes family care practice as one local primary caregiver, often female, with some support from other family members. Understanding family care from a transnational lens builds support for the importance of a feminist Ethics of Care lens and has important implications for policy and service delivery practices.

### Introduction

Canada, like many other Western countries, reflects an increasingly globalized world with almost a quarter of adults living in Canada self-identifying as an immigrant (Stats Canada, 2019). Of these, 15% are over age 65 (Stats Canada, 2019), and if they came after 1990, they likely belong to a culturally diverse community, including 48% from Asia and the Pacific region and 10% from South and Central America (Citizenship and Immigration, Canada, 2009). A majority of older immigrants have come to the country under Canada's reunification policy and are more likely to be living with and/or supported by family for at least 10 years after their arrival (McDonald, 2011).

The need to understand the implications of this culturally diverse world on the aging experience (Phillipson, 2015; Torres, 2015) and the provision of family care (Bryceson, 2019; Chappell & Hollander, 2011; Keating & de Jong Gierveld, 2015; Kirkland et al., 2015; Roberto &

Bliesner, 2015) has been recognized as an important area of study. According to Dhar (2011a), 'Culture plays a crucial role in immigrant and ethnic societies. Culture defines the identity of the transnational caregiver' (p. 69). Therefore, a more in-depth understanding about how culture informs the experiences of family care is relevant and timely in today's globalized migratory world.

At least two, somewhat disparate, bodies of literature have explored this significant issue. The first is found largely in the gerontological literature and has used a stress and burden lens as the dominant approach for conceptualizing family care in general (Humble et al., 2020; Sims-Gould, & Martin-Matthews, 2007) and for studying ethnically diverse family care specifically (Dilworth-Anderson, William, & Gibson, 2002; Richardson et al., 2019; Roberto et al., 2006; Roberto & Bliesner, 2015). This body of knowledge has confirmed the importance and complexity of cultural values on how family members perceive and respond to providing care (Botsford, Clarke, & Gibb, 2011; Dilworth-

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Anderson et al., 2002; Guo, Kim, & Dong, 2019; Pinqart & Sorensen, 2003) and the differential uptake of support, both formal and informal (Greenwood, Habibi, Smith, & Manthorpe, 2015). However, many questions remain. In particular, two gaps in this body of knowledge limit its usefulness. First, at a general level, the strong focus of the stress/burden model has tended to assume one fixed primary caregiver and resulted in an incomplete understanding of the role of the rest of the family in providing care and support (Sims-Gould & Martin-Mathews, 2007). Second, in considering ethnicity and/or culture in family care, this body of knowledge has rarely focused on finding a meaningful way to examine the significant role that immigration and acculturation may have in implicating family care practices (Guo et al., 2019).

A second body of research, found largely outside of the gerontological literature, has focused more explicitly on the role of transnationalism and migration in family care. This body of work has explored intergenerational care across the life-span including a small but growing body of research examining care of aging parents. 'Care' in this body of research has generally been extended to capture a diversity of caring arrangements and activities as proposed by Finch (1989) and Fisher and Tronto (1990). Seminal work by a Western Australian research group (Baldassar, Baldock, & Wilding, 2007; see also Baldassar & Merla, 2014) has been particularly influential as a foundation for considering transnationalism as it relates to family care in the field of aging. Their work has explored how care for an aging parent is accomplished and negotiated between family members living far apart and in different countries. During one of their first ethnographic studies, they interviewed 100 Australian immigrant families – about two thirds were of European descent with the remainder from New Zealand (8), Singapore (14), Iraq (9), and Afghanistan living in Iran (21). To capture the experiences of both the immigrant adult children and older parents in their home countries, the researchers interviewed the immigrants in Australia and the parents and other family members still remaining in the home countries. Interviews included family and immigration histories, types of communication used, travel, and reciprocal care for care receivers and care givers based on Finch's (1989) typology of family care exchange (financial, emotional, personal, practical, and accommodation). Additionally, the researchers observed and recorded how families organized space, tools, and other artifacts used for communication exchanges (Baldassar et al., 2007).

The work of this research group has made important contributions for understanding transnational care. In particular, they highlighted the diversity and complexity of how care arrangements were negotiated and managed, drawing attention to issues such as how obligation may be culturally mediated, the impact of the migration process on establishing care capacity, and the importance of technology in these care arrangements. A small literature base has built on this body of knowledge as it relates to aging family care especially in Europe (see for example, Kordasiewicz, Radziwinowiczówna, & Kloc-Nowak, 2018; Miette Sagbakken, Spilker, & Ingebretsen, 2018; Zechner, 2008). Findings continue to demonstrate the complexity of understanding these family processes, and Miette Sagbakken et al. (2018) concluded by recognizing the importance of considering both the availability of kin members but also their understanding of obligation and reciprocity and how that might reflect their embeddedness in more than one society. Despite its promise, however, this body of literature is only rarely addressed in the broader gerontological work on family care and a 'substantial void' in the caregiving literature remains in relation to understanding cultural values and processes (Lee, Chaudhuri, & Yoo, 2015), especially in relation to examining the experiences of non-Western immigrants (Dhar, 2011b; Wilding & Baldassar, 2018; Zhou, 2012, 2015).

This current study bridges these two, somewhat disparate, bodies of research. Specifically, drawing on a broad understanding of care that is consistent with Fisher and Tronto (1990); also Tronto, 2013), the purpose of our study was to explore and compare the relationships

between culture and informal family care practices across three diverse ethno-cultural groups: Chinese, South Asians, and Latin Americans living in Vancouver, British Columbia, Canada. Although transnationalism was not considered at the outset of the study, all three of these groups have unique immigration trajectories, with the Latin Americans representing a relatively recent group immigrating for political and economic reasons from South and Central America while the South Asians and Chinese have much longer histories in Canada. We explored the following questions: 1) What are the cultural interpretations and meanings of caring for an older family member within select ethnic minority communities? 2) How do cultural meanings of relationships influence the care process?

## Methods

This qualitative study drew on constructivist grounded theory (Charmaz, 2014, 2017b; Charmaz, 2017a) to explore the process and meanings of family care across non-western cultural groups. The constructivist approach is designed to facilitate development of a framework to better understand the processes individuals create around their experiences and ways of being in the world. In keeping with this, the interview was designed iteratively; the researchers began with a few broad questions in order to develop a deeper and richer exploration and understanding of concepts through reflection and theoretical interviewing. Throughout the research process, it is important to acknowledge the reciprocity that exists between the participants and researchers as well as the expertise of the participants (Charmaz, 2014, 2017b; Charmaz, 2017a). This also helps diffuse power imbalances between participants and researchers.

Adults self-identifying as Chinese, South Asian, and Latin American, and providing unpaid, informal care or support to someone over the age of 65 needing some level of assistance with activities of daily living, were invited to participate. Drawing on the work of Finch (1989) and Fisher and Tronto (1990; Tronto, 2013), we conceptualized care as a "multifaceted complex social phenomenon, entailing both emotional and material (instrumental) aspects" (Kordasiewicz et al., 2018, p. 77) – this encapsulated notions of caring for, caring about, providing care, and caring with (Fisher & Tronto, 1990) – and left it up to participants to describe what they meant by providing informal care or support. Participant recruitment initially took place through researchers' personal networks, ads, and organizations in each of the Chinese, South Asian, and Latin American communities. As the study progressed, snowball sampling was utilized, and participants were purposefully selected to ensure cultural, gender, and relational diversity.

The final number of adults included 29 participants: nine (9) Chinese (2 males and 7 females) from China, Hong Kong, and Burma. Ten (10) South Asians (3 males and 7 females) originated from India, East Africa, and England. The ten (10) Latin American participants (2 males and 8 females) immigrated from Chile, Colombia, Argentina, El Salvador, and Venezuela. Table 1 provides an overview of the family members consenting to participate.

With signed informed consent, up to three personal, semi-structured, audio taped interviews were conducted with each of the 29 individuals in the language of their choice. To capture cultural meanings and connotations and ensure carers' comfort and ease of expression, all but four individuals chose to be interviewed in their native language (Cantonese, Hindi, Punjab, or Spanish). The interviews were designed as an iterative process where three experienced researchers (each fluent in the respective group's native language/s) began with broad questions focused on family members' experiences and perceptions of providing informal care or support to an older adult, and then developed a deeper and richer exploration of concepts through reflection and theoretical interviewing. Topics included exploring how each defined giving care in terms of their own cultural beliefs and backgrounds, and how – from their perspectives – these influenced the assistance or support they provided. Consistent with a constructivist grounded theory approach,

**Table 1**  
Characteristics of caregiver participants.

Caregiver & ethnic origin	Males age	Females age	Relationships	Years in Canada
CHINESE (9**)	1 = 55–64	2 = 45–54	3 = Daughters	1–9 = 0
	1 = 85–89	2 = 55–64	4 = Wives	10–19 = 5 (2*)
SOUTH ASIANS (10)	1 = 35–44	1 = 35–44	2 = Husbands	20–29 = 1*
	1 = 45–54	2 = 45–54	3 = Sons	30–39 = 2
	1 = 65–74	3 = 65–4***	2 = Wives****	40 = 1*
		1 = NR****	1 = daughters-in-law****	1–9 = 0
LATINAMERICANS (10)	1 = 35–44	1 = 35–44	4 = Daughters	10–19 = 3
	1 = 45–54	4 = 55–64	2 = Sons	20–29 = 3
		3 = 65–74	1 = Wife	30–39 = 4
			1 = Daughters-in-law*****	40 = 0
			1 = niece	1–9 = 3
				10–19 = 0
				20–29 = 2
				30–39 = 4
				40 = 1

Note: \*The two Chinese caregivers worked outside of Canada longer than they resided inside of Canada.

\*\*Originally, 10 Chinese agreed to participate. However, one male dropped out. \*\*\*Two of the South Asians indicated that another person was also the “primary” caregiver with them. \*\*\*\*NR = no response to request for age \*\*\*\*\*One wife was also a daughter-in-law to one of the male LA participants. Of LA Americans, 2 were only children.

interview questions were honed and refined throughout the data generation process to explore emerging concepts and understandings. Follow up interviews, ranging between a couple of weeks to a month after the first interview per the accessibility and schedule of participants, were conducted, and for some a third meeting, focused on expanding and verifying insights. At the end of the final interview, a demographic questionnaire was completed orally with each participant to collect information about both the carer and care receiver (for example, age, education, health status, financial resources, time in Canada, citizenship, and others). Ethical approval was obtained through the Ethical Review Board from the University of British Columbia.

Table 2 below provides a picture of care receivers as described by their relatives. Each family was caring for or assisting at least one parent, spouse, or relative ranging in age from 65 to 100. Some care receivers were healthy and independent while others had severe health problems such as Alzheimer's, heart problems, or other diseases. In keeping with Canada's family reunification program (McDonald, 2011), 27 of the 29 older adults had immigrated to Canada to reunite with their families. Although only two Latin Americans still resided in South America, visiting their adult children only when economically possible and based on immigration policies, they planned on immigrating at a later date. Furthermore, the 27 care receivers had lived in Canada for 10 years or more and in some cases, even for 30 to 39 years (10). Also, most care receivers (22) either lived with the carer or a family member.

Data analysis was a collaborative (team), iterative process using a strategy consistent with the constant comparative method. First, all taped interviews were translated verbatim, (to capture cultural meanings), into English by the respective research associate who conducted it. Next, a three-stage process began with the research associate affiliated with each of the three groups analyzing several interviews and coding them. Then, associates with the principal researcher in Vancouver met to discuss the interviews to analyze meanings, initial codes, and compare these among the three cultural groups. Using these team decisions and codes, a code book was developed. It was then used to conduct a line-by-line coding of each transcript. Atlas-ti facilitated this coding process. Once data was coded, the research team began looking for links among codes to develop categories, for creating broader themes as they began to emerge. These were then refined and developed through subsequent interviews with the participants and by returning to the data.

### Results: Fluidity and flow as a foundation of cultural family care

Data revealed a process of family care that was complex and dynamic across all three cultural groups. Specifically, a sense of flow and fluidity created a picture of care as a shared phenomenon – across family members and geography – that was highly dependent upon communication technology. Hence, a significant theme that emerged across all three groups was the importance of conceptualizing family care as a transnational, collective undertaking underpinned by three themes: broadening the conception of ‘family care’; locating family care as transnational; and increasing reliance on technology.

#### Broadening the conception of ‘family care’

In this study, consistent with existing research (Baldassar et al., 2007; Dhwan, 1998; Flores, Hinton, Barker, Franz, & Velasquez, 2009; Guo, Li, Liu, & Sum, 2015; Hsueh, Hu, & Clarke-Ekong, 2008; Pharr, Francis, Terry, & Clark, 2014), family care emerged as a normative cultural expectation in all three groups. However, each labelled and described the concept differently. For example, for the Chinese (CH) participants, this revolved around the language of filial piety and/or ‘ganqing’ based on a relational sense of moral duty and responsibility, resulting from Confucianism. These values were generally volunteered spontaneously and explicitly:

It is our “culture” to “look after” the elder. It's more emphasized in our education from when we were kids...although my parents never said: ‘You have to take care of me,’... But from a young age when we were “brought up,” you know “ganqing” [you feel you] have to take care of him/her... especially those with Alzheimer's (An<sup>1</sup> –CH daughter caring for mother, age 80, with Alzheimer's).

Supporting this perception as a culturally expected norm, Sing Mei, caring for her Chinese parents, noted: ‘I see my other friends, they also doing the same thing to their parents, to take care of their parents’ (Sing Mei – CH daughter caring for parents, ages 75+).

South Asian (SA) participants also positioned family care as a normative cultural expectation, but they were more likely to draw upon a religious understanding: describing caring for seniors and others as part of their religion where caring for others is an ingrained culturally expected religious responsibility to serve God and, thus, others. For instance, depicting this link between ‘seva’ or religious service and ‘farz’

<sup>1</sup> Pseudonyms were assigned to participants to ensure confidentiality.

**Table 2**  
Characteristics of care receivers.

Care receiver	Males age	Females age	Health issues	Relationships	Living arrangements	Years in Canada
CHINESE (10*)	3 = 75-79	1 = 75-79	3 = Alzheimer's1 = Dementia	2 = Wives	8 = With caregiver	1-9 = 0
	1 = 85-89	3 = 80-84	2 = -stroke1 = cancer	3 = Husband	1 = with son & daughter-in-law	10-19 = 7
		2 = 85-89	1 = diabetes2 = prostate	4 = Mothers	1 = Independently	20-29 = 1
			2 = glaucoma2 = hard of hearing***	1 = father		30-39 = 2
						40 = 0
SOUTH ASIANS (13*)**	2 = 70-74	2 = 65-69	2 = Alzheimer's	8 = mothers	7 = with caregiver***	1-9 = 0
		1 = 70-74	1 = bedridden	3 = Fathers	4 = independently	10-19 = 7
	2 = 75-79	2 = 75-79	1 = brain hemorrhage	1 = Wife	1 = care home	20-29 = 2
		2 = 80-84	9 = no health issues reported	2 = Husbands	1 = with CG's brother	30-39 = 4
		1 = 85-89		1 = mother-in-law		40+ = 0
		1 = 100+				
LATIN AMERICANS (11*)	2 = 75-79	2 = 65-69	3 = Alzheimer's	7 = mothers	5 = With caregiver*****	1-9 = 0
		1 = 75-79	1 = pace maker***	1 = father	3 = independently	10-19 = 2
		2 = 80-84	2 = diabetes	1 = husband	3-nursing homes	20-29 = 1
		1 = 85-89	1 = prostate cancer	1 = daughter-in-law		30-39 = 4
		3 = 90-94	1 = stroke	1 = aunt		40 = 2*****
		3 = old age			2 = visit c& live in South America	
		2 = healthy				

Note: \*Number of care receivers is greater because some caregivers are caring for more than one person. \*\*One South Asian caregivers was also a care receiver. \*\*\*Chinese indicated 2 health issues; 2 Chinese indicated 3 health problems; 2 Latin Americans reported 2 illnesses \*\*\*\*Although some of the South Asians indicated that the CR lived with them, in actuality, a number would live part-time with others in the family assisting with care. \*\*\*\*\*One CR was a Canadian by birth but had lived outside of Canada for a number of years. \*\*\*\*\*One Latin American CR was born in South American but resided in the US \*\*\*\*\*Some started out living independently and then lived with CG or returned to independent living, or started out living with CG and then moved o a nursing home.

or cultural responsibility, Kavya, a South Asian wife, caring for her husband and living with their daughter stated: 'Culture, we are so religious from inside that we are taught from the beginning culture and religions, they are the same, and they run parallel.' Kavya explained further:

Our foundation is such right from the start; serving others is like our religion. It is like serving God when we look after someone who is sick. We are told from childhood to look after sick people. What our children are doing...is part of our culture. In our culture, we teach to share. We shared with them; they are returning it to us.

(Kavya - SA wife caring for husband, age 70+)

Although religion is an important underlying value for the Latin American (LA) participants in this study, they described and explained caring for elders, family, and friends as 'deber' or duty. Here, "family obligation" was based on the notion of collective loving family relationships and loyalty to family cultural values that extended beyond duty to immediate family into the community of friends. Sandra, a previously paid health care provider, recently retired to care for her aging Chilean mother, captured Latin American cultural caring as collective and communal:

As a family member, there is the affective aspect. Never would I leave a parent, a very good friend, godmother, or whatever, if they don't have a family member or a person close to them. I feel that it is my "deber" (duty and obligation) for feelings for sentiments. I feel it is my "deber" to take care of/be concerned with that person, pay attention to them.

(Sandra - LA daughter caring for mother, age 94)

Caring for elders as a social expectation of being a 'good' son, daughter, or family member in the kin relationship network, then, was consistent across all three cultural groups. These cultural expectations also extended to friend networks described by many participants from all three groups. Moreover, participants explained this care was a reciprocal act embedded within the social fabric of the culture. Subtle differences in the foundations for understanding these expectations emerged, however. Caring obligations appeared to be linked explicitly to religion for South Asian participants, but it seemed more related to the teachings of political philosopher, Confucius, for the Chinese whereas Latin Americans tended to describe caring as a more collective

sense of family extending beyond blood relationships.

Importantly, across all three cultural groups, this notion of family care was communal, embedded in a loose definition of the extended family network that included friends, blood relatives, and relational family. To illustrate, in our study, carers did not define a primary caregiver, but they discussed caring in terms of networks and relationships. Even only adult children like Argentinian Rossana pointed out that she had created networks from her family (husband, daughter, and grandchildren, among others) and paid companions as well as her 92-year-old mother's long-time friends to provide support and care. Another Argentinian, 50-year-old Casimiro, an only adult son, drew on his partner and extended family, like his female cousin living in Seattle to provide support and companionship for his aging mother living independently. Casimiro commented:

My cousin, Andrea, who is like my sister, comes from Seattle every two months, and sometimes she stays for a week with my mother to keep her company. When I am here at my breaking point, she comes. She takes over. She releases me. For example, she came last week, and she cooked for two weeks. She leaves things prepared. She cares for my mother all the weeks. She takes her; she brings her back. She gives me license...

(Casimiro - LA son, only child, assisting mother, age 81)

Thinking further about his support network, Casimiro explained:

When I have problems with her [my mother], Andera, my cousin, and Daniel, my partner, are the two people who assist me...ahhh. I have a very good friend of hers in the [Spanish community] group also.... That woman is very, very good also, and she helps me too... yes...she knows her [my mother] very well. She is from Ecuador, and she knows the Latin culture very well, so she cheers me up.

(Casimiro - LA son, only child, assisting mother, age 81)

Care was often described in terms of friend networks that provided support. For example, Yoyi, a Colombian business woman and daughter-in-law noted: 'In my country, (laughs) if someone is sick, 20 people arrive to care for them' (Yoyi - LA daughter-in-law coordinating care for mother-in-law, age 89) while a SA daughter, Aaliyah, commented, 'My White friends get very surprised that my friends come right away when I need them.' Furthermore, Aaliyah (SA) explained that friendship was much more:

I went to India after 16 years, believe it or not, my friend kept my mother with her for a full month. Who would do that? I can't imagine. My mother was very happy. If she [friend] hadn't, we couldn't have gone to India. We both had to go, me and my daughter, we couldn't have thought of it. We didn't worry at all. It is our culture. If there is anything, I know that my friends are here, I don't have family, but my friends will be there.

(Aaliyah – SA daughter caring for mother, age 80 +)

In essence, two types of friend networks emerged during conversations with participants: friends of carers (as pointed out above) and friends of care receivers. Although care receiver friend networks may not have provided direct care for their aging friends, they offered different types of support. This 'care' was more supportive and reinforcing companionship. Five of the LA participants spoke directly to the importance of this support: For example, Rossana, an only child, maintained:

[My 92-year-old mother] has two friends, well, she had. She has another friend who telephones her every so often.....Sometimes she goes to visit her, but only once a month, but my mother counts on that. My mother has a little book where she has everyone's telephone number written down, and she calls... She asks people to call for her because she can no longer dial because she has lost her dexterity, so someone dials for her, and so she can talk.

(Rossana – LA daughter, only child, caring for mother, age 92)

The deeply embedded cultural values, perceptions, and actions held by these three ethnic groups regarding family care created tensions within the Canadian context for some, especially for those individuals dealing with relatives suffering from Alzheimer's or severe illness. For instance, a recently retired Chinese daughter, An, whose mother with Alzheimer's lived with her and her retired Chinese husband recognized the stress of this tension as she talked about how she had visualized her retirement quite differently:

...after I retired, I was hoping to live the life of a retiree, hoping to do some traveling and enjoying life in retirement, doing more activities. But because I have to take care of an elderly [80-year-old] person with "Alzheimer," I can't do what I want to do personally.

(An – CH daughter caring for mother, age 80, with Alzheimer's)

For An, even though caring for her aging mother was causing stress in her marriage, as a Chinese wife and daughter, pointed out:

This situation is – ...because she's my mother, and she's very afraid of going into a seniors' home, and I can't – my heart myself – basically I'm Chinese, so "until" she really cannot "manage" one day, I mean when I cannot "handle" her "at home," I cannot bear to send her away to a seniors' home.

(An – CH daughter caring for mother, age 80, with Alzheimer's)

Other participants from the three cultural groups articulated views about cultural tensions between the Canadian context and embedded cultural values of their elders. According to Abhijeet, a retired South Asian son, caring for his 100-year-old mother, 'There is culture in us,...a 30-year culture...we brought with us [when we immigrated to Canada], ...still alive in us. We know, it is not for us, we know...elders from India, after 60, when their life is almost over, they cannot change' (Abhijeet – SA son caring for mother, age 100).

Sandra, the LA retired health care worker, addressed the necessity of balancing Canadian beliefs and way of life with her cultural values since she has a Canadian born son and her 94-year-old Chilean mother living with her. Sandra was clear, however, that she would ensure that her Chilean mother's cultural family caring beliefs would be respected and honored despite what others might say.

The doctor told me, "...well... there are institutions where you can put your mother." I said, "Forget it! Forget it! My mother is never

going to be in an institution either." Because the doctor is also Chilean, and he would say, "Forget what I said. Forget it." Because I would just look at him, "Do you really think my mother would accept going there?"

(Sandra – LA daughter caring for her mother, age 94)

Nevertheless, as a 17-year immigrant to Canada, Sandra's changing values were reflected in her views of her own future old age in Canada.

I say to my son, "Forget it. I am Canadian now. The day that I begin to fail, in front of my house, there is a nursing home, you don't have to do any more than cross the street, and you put me there" (laughs). Because my son is Canadian, and he's going to marry a Canadian girl, so then I must accept that the Canadian family is different so his wife might think, ya the woman [mother-in-law Sandra] is very slow, and there [nursing home] she will be very calm.

(Sandra – LA daughter caring for mother, age 94)

Other participants expressed similar changes in their values the longer time they spent in Canada.

Participants found different ways of balancing conflicting values. For instance, Chang, an 89-year-old retired Chinese accountant and husband caring for his wife with Alzheimer's, explained how living in Canada for over 39 years had shaped his ideas: 'I got it [other views] from this Canadian free society. My attitude towards old ideas, those old Chinese things, I discard them totally.' His adoption of new ideas extended to differences about traditional views of filial piety and family care and use of assisted living facilities. 'Once I saw from the things they [organization] said, there would be care for this and that, I said, what a great opportunity, why wouldn't I join? How often would you find an opportunity like it?' Chang contrasted his perspective as a long-time immigrant to those with more traditional Chinese values:

They [Chinese] have different ideas. They have old ideas. They say an elderly person should live at home [with family]. Why would they go into old people's places? They should be with family. I say: You don't understand. For me, I like to have clear boundaries and hierarchies.

(Chang – CH husband caring for wife, age 88, with Alzheimer's)

Despite some accepting the changes in cultural values, Abhijeet, retired South Asian son and husband, a long-time resident (17 years) of Canada, expressed the tensions that emerged in all three groups in this way:

My parents, my father, her [wife] parents, my grandfathers, these are their pictures. When they were aged, they were looked after. At that time, the culture was different. Now, it has changed. People over here are westernized, who bothers? Go and leave your mother there [nursing home]. We'll pay money there. Your attachment?.

(Abhijeet – SA husband and son caring for wife, age 68, and mother, age 100)

In summary, family, kin, and friend care networks often were bounded, at least loosely, along cultural lines in their beliefs, intentions, perspectives, and actions. Participants across all three cultural groups in this study drew firmly upon cultural beliefs about family care to make sense of their actions and responsibilities. For many, cultural perspectives about family care helped them explain their own sense of responsibility. Importantly, however, cultural values also set the foundation for caring arrangements that were much more communal and relational. The sense of responsibility, however, could create tensions as participants experienced perceived cultural clashes regarding the understanding and meaning of familial care.

#### *Locating family care as transnational*

A surprising theme to emerge early in this study was related to the relevance of geography and mobility to the flow of care. Care processes



were fluid, often transcending national, international, and geographical boundaries. Mobility involved all members of the care network, including the person being cared for.

Geographical flow of care often consisted of the care receiver being cared for or supported across multiple households and geographical borders – both within the immediate locality as well as across different countries. Furthermore, individuals providing some type of support or 'care' varied in terms of the type of relationship (immediate family; extended family; or friend networks) and location. One description of the mobility of the flow and fluidity of care between households by the immediate family was explained by Chaaya, a South Asian daughter, sharing care of their mother with her sister:

Mummy, from the time she came from India, first she lived with me, and later my sister moved out, and now she lives with my sister. Half the week she lives here, and the other half she lives with my sister, and she has a very flexible schedule, and we are happy to keep her with us. There is joy in the house, that there is an elder in the house.  
(Chaaya – SA- daughter caring for mother, age 67)

While the movement of this flow of care often occurred with immediate families at the local level, particularly for frail care receivers, surprisingly, mobility of care receivers took place fluidly across transnational borders. It was not uncommon for older adults, particularly if health allowed, to spend time (often months) with family members either between different households locally or dispersed throughout North America and/or transnationally in a former country of origin. Often, it was difficult to determine what country or geographic location was 'home' to the older adult care receiver given the frequency and regularity of these mobile relocations. Although some Chinese and South Asian individuals were mobile locally and nationally, this transnational movement phenomenon tended to be more frequent among Latin Americans. What was clear in the data was the complexity of facilitating this geographical movement. To illustrate the intricate and complicated support arrangements created by extended families, Margarita, Chilean only daughter, caring for her 90-year-old mother later diagnosed with Alzheimer's, described:

I have a cousin who lives in Los Angeles. She is my mother's niece, and she called me one day and said, "I'm going to Chile. Do you want me to take my aunt?" I said, "Yes," so that we bought her a ticket so that she could go to Chile, and so that afterwards she would be able to go to Brazil. I have a son in Brazil. We bought her the ticket. I, my boyfriend, and my mother travelled to Los Angeles where my cousin lives, and from there my cousin took her to Chile, and, initially, she was going to stay with her brother there, but it didn't work out, and before she left, we looked for another arrangement, and a distant relative, said that she could have her in the house, and for a reasonable amount of money so much so that she went there for a month, and after a month, she went to my son's house in Brazil.

(Margarita -LA only daughter caring for mother, age 90, with Alzheimer's)

As explained above, planning trips was extremely cumbersome. Participants not only had to take into account the complicated nature of planning travel for their aging parents, but they needed to account for other factors influencing movement across international and national borders. For example, Ignacio, the youngest son of three Colombian brothers, explained that although his 68-year-old mother was independent and able-bodied,

She is afraid of airplanes, so she cannot come alone. She is very frightened of airplanes, [and] she speaks absolutely nothing of English, or rather, for her to come alone is not an option either..." To counteract these issues, "we need to go there and bring her here, ..." and then accompany her back when she returns to Colombia.

(Ignacio – LA son assisting mother, age 68)

Ignacio pointed out the importance of revising immigration, airline, and health policies, and programs to facilitate travel for aging migrant parents: 'If they [policymakers, healthcare professionals, airline owners, or others] would simplify the way to bring parents, that way they would not have to become permanent residents or citizens.' He described ways travel could be facilitated and more accessible for older as well as frail adults.

....a program,..., where someone could bring them [older adults], and one wouldn't need to go and bring them here, rather that there would be a system where someone could bring various at a time, accompanying them in the airplane and helping them with running around for immigration. That would exist a way in that they could have tickets, a discount on the air fares....in the future an easier and faster way would exist that if the children are here, and the parents are alone there to make the immigration process faster because the time that they are there alone, well, it could become a risk that they experience other inconveniences because they are alone.

(Ignacio – LA youngest son assisting mother, age 68)

Finally, not only was the older adult mobile, carers also travelled within or between cities nationally or internationally to help provide care for aging relatives. Jasmine, a Chinese Canadian daughter, stated:

[When I was] away in Toronto for a brief period, about a bit more than a year, my sister came to live with her' [their mother]. ..., my sister, my brother-in-law, and my father were with my mother. In the end, they left, went back to Hong Kong. In 2002, I came back from Toronto to be with my mother.

(Jasmine – CH daughter caring for mother, age 80+, with Alzheimer's)

#### *Increasing reliance on technology: the how of caring*

A prevalent theme underpinning the data from all three ethnic family networks indicated the importance of technology for facilitating an approach to family care that promoted a geographically fluid caring experience. In its least sophisticated form, technology included regular telephone contact – both locally and transnationally – with other family members and the care receiver. However, it also involved taking advantage of 'newer' technologies such as email and Skype.

The importance of telephone connection was highlighted by many: 'Comfort was just a phone call away,' noted Chaaya, a counselor and SA daughter. It enabled sibling and kin caring for older adults to be in 'communication all the time, absolutely, all the time, so that, well, or rather directly with her and through my sisters...' (Chaaya – SA daughter sharing care with her sister of their mother, age 67).

Low cost international calling was relied upon extensively. Regular phone contact – sometimes daily – was maintained between family networks. This ensured all members were involved in daily life and decision making for the senior and family. It also helped reduce stress for those currently providing hands-on care and ensured all family members had an understanding of the older adult's care needs. This allowed each family member to contribute to care decisions as they emerged daily based on each person's abilities and time to assist with and participate in the care and support process.

Meiling, 73-year-old Chinese wife, caring for her 77-year-old husband with dementia e pointed out:

Our daughter came two years ago to see her daddy, but she has work and children and family, so they can't come every year....they have to wait for the right time, the children's summer holidays, to come over. So we rely on telephoning. They call 1, 2, or 3 times a week to talk with us. It's good. At least with the phone call, you get to know the situation. You can talk...Now, they ask how's life with daddy, how he's deteriorating, get to know his conditions, that can help me reduce my stress [laughs heartily].

(Meiling – CH wife caring for husband, age 77, with dementia)

Illustrating the many ways phone calls were used strategically, one son, Ignacio, – a physician working in Canada as a researcher – telephoned not just to keep his mother in Colombia close to him but also to assist in monitoring her health:

In actuality, we do it [call] once a week, and I ask her how her health is, if she has had medical appointments. I always find out what happened during the medical appointment, what medicines, what exams they ask for, what prescriptions she is taking, how she is feeling. Perhaps, her health is the most important thing that I am aware of in addition to that, her emotional state.

(Ignacio – LA son assisting mother, age 68)

While not a replacement for actual physical contact and recognizing the complexity and financial cost associated with travel, phone calls were helpful. Much of the calling was, not unexpectedly, between members of the family kin network, but the potential value of using telephone contact with health professionals strategically to keep family aware and involved, was also raised. Thinking about his mother, Ignacio suggested:

-To find a way that the doctors there [in Colombia] can communicate with the children here [in Canada]...one could send them an email or tell them...a communication bridge to tell them how he found my mother, what needs to be done, because my mother goes to the doctor, and the doctor explains a mountain of things in medical terms that she is not going to understand. She goes home, and I ask her how it went, and she tells me fine.

(Ignacio – LA son assisting mother, age 68)

Frequently, telephone calls were used to share news, keep in touch, and communicate – often daily. Usually, these calls dealt with the mundaneness of daily living and celebrations. Some extreme examples demonstrated the importance of contact as a lifeline. For instance, one Venezuelan niece, Leila, described how a visa problem limited her ability to travel, so she had to rely on an international call to talk with her dying aunt. Previously, Leila had cared for her aunt for more than 15 years in the US. Devastated that she could not be by her aunt's side in her last moments, Leila remembered saying as she listened over the phone to her aunt's labored breathing:

Little Aunt, you are with God. Never be afraid because God is with you. You will see that you are going to be super well. God loves you. I don't know how much. I love you so much, you know.

(Leila – LA niece caring for aunt, age 75, with Alzheimer's)

Leila recognized the importance of emotional caring by an extended family member as a fundamental aspect of care. The warmth of family caring could not be replaced by professional caregiving – and her simple use of telephone contact allowed Leila to continue providing loving, heartfelt, emotional support, connection, and comfort.

Not being able to be there..., it was like disappearing from her life. Before that..., we talked, and all, but.....it was that I was there at every moment for her [when she had been caring for her aunt with Alzheimer's on a daily basis in the US]. The woman [professional caregiver] she had was excellent, but it was not the same quality, or rather the love, or rather the quality of care could have been very special, very professional, and all, and...very affectionate, Latina, ..., quality, but nothing like the love of the family.

(Leila – LA niece caring for aunt, age 75, with Alzheimer's)

Despite its utility and importance for emotional support, comfort, and communication, technology had some downsides. Even with reduced costs of international calling cards, daily international calls still remained expensive. Moreover, telephone calls could be intrusive to one's personal life as explained by Casimiro, Argentinian son, an only child:

If she [my mother] needed something, she would call me a number of times. I tell you that because if not, she becomes another of the things; this ...is very interesting. With her, one must have balance because I visit her every day. She becomes very possessive, and afterwards, she thinks I have the obligation! At the same time, when I answer the telephone every time, but I do not answer one time, she says to me, "Why didn't you answer the telephone!" ...I say, "Mami, I am working. I am doing business. Sometimes, I cannot attend to you. Leave me a message, and I will answer you." It is something very interesting. It is like an education...if I answer her immediately every time, sometimes when I do not answer, it is "Oh, lala!" (laughs).

(Casimiro – LA son, only child, assisting mother, age 81)

Beyond the telephone, other types of technology – for example, Skype – emerged as an important facet for facilitating more traditional views of collective caring and played a key role in uniting local, national, international, and transnational 'carers.' It brought family members at a distance closer together in terms of proximity, particularly for some Latin American participants. A vivid illustration of how technology facilitated day-to-day involvement was offered by Antonia. Despite residing a continent away, this 37-year-old female doctoral candidate described the continued closeness between her two sisters living in Venezuela, her mother, and herself in Canada. Antonia pointed out that through technology, she, as the youngest daughter, was in constant communication with her mother in order to be part of and share experiences with her mother's daily life:

By...using Skype, we also see each other. Then, if she goes Saturday to have lunch at my sister's, my nieces turn on the computer. I say, Mami, get on so that I can show you the little flower that bloomed on the plant. Then, I show her through the house with the computer showing her the little flower, and it is so wonderful...It feels wonderful because she knows... As if she had come to actually see how it is doing, what the house is like here, and if the plant, and if it grew or if it didn't grow. I show her how...I hung a few new pictures. Then, through Skype, I can see the paintings. This makes it easier.

(Antonia – LA youngest daughter supporting mother, age 66)

Technology played an important role in facilitating and fostering the fluidity and flow of care for cultivating a sense of closeness, proximity, and presence of family, kin, and friend networks caring for and involved in the life of the older person and family. As described by all three family cultural groups, technology spanned local, national, and geographical distance and transnational borders to bring comfort, support, presence, closeness, and involvement in decision making while allowing family, extended kin, and friends to participate in seniors' daily lives and experiences at a distance.

### **Discussion: who exactly is 'the' carer, and where is this care taking place?**

Recognizing the importance of culture within a context of informal family care, the research team for this study sought to better understand the process of family care within three ethnic communities in Vancouver, BC, Canada. A broad understanding of giving care was adopted, allowing participants to self-identify their role in the care process from their cultural perspectives. This, perhaps, set the stage for the importance of fundamentally challenging conventional ideas associated with the study of family care in North America that has often focused on one 'primary' caregiver. Specifically, across all three cultural groups, our findings support an understanding of family care as truly occurring within broader family kin (and friendship) networks that tended to be culturally bounded, often loosely, but not geographically constrained. This meant that in all three cultural groups, but especially with the Latin American participants, it was often difficult to name a 'primary' caregiver since even only children, like Rossana and Casimiro,



created extended kin and friend support networks that aided in the provision of support and care. Consistent with this approach, none of the family carers identified themselves as the 'primary' caregiver. The notion of a primary carer was further disrupted by the mobility and use of extended travel by both the older adult to live with other family members and/or by family members spending time with the older adult making it difficult to even determine the location where primary care was being provided. Our participants described complex negotiated decisions made by kin networks as a collective family undertaking about how, when, where, why, and by whom care and support would be provided to aging seniors. Care was fluid and flowing throughout individuals, networks, time, space, distances, and ages. This suggests to us the need to extend ideas about aging in place – a term that commonly directs policies and practice – to consider more specifically the notion of 'aging-across-place' (R. Beard, personal communication, August 17, 2020) as a relevant concept for understanding care within culturally diverse, immigrant groups.

These findings position family care using a lens that is far broader and relational than the narrow focus on the provision of instrumental care that has typically dominated understanding of family care within conventional gerontological literature. Hence, our findings support the much more inclusive and complex approach to care offered by scholars, such as Finch (1989) and Tronto (2013). Tronto has developed the concept into an Ethics of Care framework. Grounded in feminist relational theory, an Ethics of Care lens captures the reciprocity of care in that we are all interdependent, both receiving and giving care throughout our lives. In this framework, Tronto identifies five principles to guide the provision of care: attentiveness, responsibility, competence, responsiveness, and solidarity. These correspond to five phases of care: 'caring about,' 'caring for,' 'care giving,' 'care receiving,' and 'care with.' These phases are fluid and can operate simultaneously and sometimes contradictorily, across different relationships. Pragmatically, the phases and corresponding principles capture the complexity of the caring process and provide a useful lens for exploring relationships: purpose, needs, emotions, and power. This framework lens may be especially important for understanding the interface between the experiences of family and formal care, particularly within ethnically diverse communities where underutilization of formal supports has, in many cases, been identified as a problem.

Second, our findings raise questions about how place of residence may be re-interpreted and understood as a more fluid concept than is typically assumed with movement occurring at the local, national, and international levels. In raising these insights, the study contributes to the understanding of family care as a transnational global phenomenon and bridges two important bodies of research. As identified in the introduction, migration scholars introduced the importance of a transnational perspective to describe and conceptualize relationships in individuals and communities develop and sustain across geographical distances and national borders (Baldassar, 2007; Horne & Schweppe, 2017). With few exceptions (Baldassar, 2016; Baldassar et al., 2007; Merla, 2014), this lens has rarely been applied to the study of aging and/or understanding family care of older adults (Amin & Ingman, 2014; Horne & Schweppe, 2017; Näre, Walsh, & Baldassar, 2017; Zechner, 2008), especially related to non-western cultural groups (Dhar, 2011b; Torres, 2015; Wilding & Baldassar, 2018; Zhou, 2012, 2015). This lens did not initially inform our research. However, the importance of it emerged early on in the data generation phase, and, consistent with a grounded theory approach, was used to help question, refine, and develop understanding. For example, we began to explore the fluidity and flow of care, role of technology, and describe how some ethnic older adults experience this notion of aging across different geographical places. Our research suggests that this lens has much to offer to the study of family care in gerontology and supports findings by Baldassar et al. (2007, Baldassar, and Merla, 2014) that family care does not need to be proximate in order to be effective.

A transnational lens draws attention to a number of areas that

require further exploration and development. First, consistent with the work of Baldassar, Nedfciu, Merla, and Wilding (2016); Wilding, 2006; Wilding & Baldassar, 2018), and others (see for example, Ahlin, 2020; Lee, Lee et al., 2015), the promises and challenges of information communication technology (ICT) for facilitating a more holistic understanding and enactment of 'family care' emerged as a critical aspect of family care that requires further examination. Our findings lend texture to Wilding's (2006) suggestion that technologies blur lines of imagined proximity and physical separation as families creatively incorporate diverse types of technologies into their provision of care to meet cultural, social expectations, and health needs in these contexts that tend to be particular to specific points in time. It supports the value of ICT for 'enacting everydayness' (Ahlin, 2020), p. 76 as a key theme related to 'good care at a distance.' One powerful example of the blurring of distance and time in this study was the graduate student, Antonia, having lunch with her mother daily via Skype. An understanding of the importance of ICT also highlights ways of re-visioning the provision of formal support. For example, family conferences using supportive technology may help ensure that the entire family – irrespective of geographic location – has the necessary information to provide quality care and support, particularly for ethnic collective cultures. Ensuring both the availability and uptake of effective communication technology infrastructures and digital literacy for older adults and their families will be an important area for research and service development. This is especially urgent in these times of COVID 19.

Our study also supports the works of Bryceson (2019), Wilding and Baldassar (2018), and Zhou (2012, 2015) that focused on the need to better understand how structural issues may impede the process of family care. Transnational care or 'distant care' has received little recognition in the area of policy development (Baldassar & Merla, 2014), and yet, as identified by at least one participant, Ignacio, in our study, policies and practices, for instance around travel, may deter families from being able to care and provide culturally appropriate support in the way that they want while residency requirements may act as barriers for use of health and social care support services. Future research is needed to understand how diverse health and social policies in both the home country as well as the country of immigration impact family care ( Lee et al., 2015).

Finally, attention to the notion of care as fluid and flowing for both able-bodied as well as those who are frail or ill emerged from our study as an important finding. 'Flow of care' related to the presentation of negotiated, reciprocal, and shared family collective informal care was based on ability, availability, and capacity to care, occurring in motion, fluidly, through time and space as the care receivers transitioned and moved geographically to be with family as they aged and/or family moved to be with them. In addition to being consistent with an Ethics of Care framework, this notion develops further the work related to the circulation of care being developed by Baldassar and Merla (2014); Merla & Baldassar, 2016). The concept of care circulation offers a broad view on transnational care through its focus on 'the reciprocal, multi-directional, and asymmetrical exchange of care that fluctuates over the life course and within transnational family networks subject to the political, economic, cultural, and social contexts of both sending and receiving societies' (Baldassar & Merla, 2014, p. 25). In some of their work, they have examined how the older adult contributes in this circulation of care: an important limitation of our study is that we did not explicitly explore the role of the older person in the family care process except in relation to receipt of care. Further research is needed to broaden and deepen the picture of family care, addressing more explicitly the role of reciprocity within the process.

## Conclusion

Through this study, we explored the process of providing informal care to a family member within three diverse, non-western cultural

immigrant communities. Findings highlight the importance of recognizing family care as more communal and geographically fluid, supported by the innovative use of technology. The study suggests the need for a reframing of our understandings of family care – for example broadening moving from a notion of ‘aging in place’ to one of aging across geographical locations – and the need for policies and practices that can accommodate a different way of providing family care. We need to reinterpret care as flowing freely and fluidly throughout family, kin, and friend networks of informal, collective, and communal care through space, time, and distances locally, nationally, transnationally, and globally.

### Declaration of competing interest

No conflict of interest existed by the authors.

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### Ethics statement

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