Abstract: Providing home health care to family members presents many physical and psychological stressors. Health care professionals frequently counsel family caregivers to seek respite by temporarily delegating caregiving responsibilities to others. However, when viewed from the perspective of rhetoric, definitions of respite as private time away from the care recipient are culturally bound ideographs and may not be appropriate outside North America. This qualitative study explored North American–trained social workers practising on the Caribbean island of St. Kitts as they promoted a concept of respite care defined by North American norms. Family caregivers interviewed rejected this model of respite care, situating their caregiving within the context of established family relationships.

Keywords: Respite care; Family caregiving; Ideographs; Patient-family communication

Résumé : Dispenser des soins de santé à domicile aux membres d’une famille présente de nombreux facteurs de stress physiques et psychologiques. Les professionnels des soins de santé conseillent fréquemment aux fournisseurs de soins de rechercher un répit en délégant de façon temporaire leurs responsabilités médicales à d’autres. Cependant, du point de vue rhétorique, les définitions de répit comme étant un moment d’intimité loin des bénéficiaires des soins sont des idéogrammes culturellement limités et peuvent ne pas s’appliquer en dehors de l’Amérique du Nord. Cette étude qualitative s’est penchée sur des travailleurs sociaux nord-américains exerçant dans l’île de Saint Kitts, aux Caraïbes, qui lançaient un concept de répit défini par les normes nord-américaines. Les fournisseurs de soins aux familles interrogés ont rejeté ce modèle de répit, plaçant leur action médicale dans le contexte de relations familiales solides.

Mots clés : services de répit; soins familiaux; idéographies; communication famille-patient
Introduction
Throughout the world, changes in the demography and epidemiology of disease, together with changes in practices of health care delivery, have precipitated a steady increase in the number of chronically ill individuals receiving long-term health care from family members in their home (World Health Organization, 2006). The stressors of caregiving have compelled many researchers and health care professionals to seek ways to assist family members in providing care to their ill and disabled loved ones. Effective communication between professional and family caregivers is one essential factor in the success of such interventions.

The purpose of this project was to examine the communication between family and professional caregivers on the Caribbean island of St. Kitts as they negotiated definitions of acceptable family caregiving activities. Analysis of interview data collected during a six-week research trip revealed that while professional caregivers, all of whom were educated in North America, frequently spoke of caregiving work in the language of professional health care, they were also aware of how these professional norms conflicted with local cultural values. For their part, family caregivers tended to reject professionals’ depictions of caregiving that were culturally dissonant, particularly the advice to seek respite through relinquishing caregiving duties to others outside the family circle. Instead, family caregivers advanced definitions of respite that brought them closer to family life rather than isolating them from it.

The results suggest that while professional and family caregivers constituted a single community of care, there were important differences in the ways in which the stakeholders viewed key values that defined caregiving work. Michael Calvin McGee’s discussion of ideographs in deliberative discourse (1980) provides the theoretical underpinning for our examination of the polysemy and evolving meaning of terms related to these key values. By shedding light on the communication process between professional and family caregivers, McGee’s discussion can suggest avenues leading to improved professional communication practices.

Family caregiving
In Canada alone, roughly three million adults provide care to disabled, chronically ill, or frail family members annually (Decima Research, 2006). Family members provide care for all types of physical and psychological illnesses (Perry & Bontinen, 2001), to patients of all ages and levels of need (Nolan, 2001). Worldwide, caregiving produces physical, social, emotional, and financial stressors that have the potential for severely undermining caregiver well-being (Ingleton, Payne, Nolan, & Carey, 2003; World Health Organization, 2006). Additional health deficits may occur when the caregiver neglects obligations to other dependants (e.g., healthy children, elderly relatives, not to mention self-care), thus creating a cycle of decreasing caregiver ability to meet an increasing burden of care.

The dangers to physical and psychosocial health have prompted practitioners and researchers to seek interventions to alleviate caregiving stress. These interventions are of two general sorts. The first category of intervention seeks to remediate family caregivers’ deficits in practical knowledge, such as by providing training in
physiological and technical aspects of care (Fedewa & Oberst, 1996) or improving access to professional health care support (Davies & Nolan, 1996). The other category of intervention focuses on the emotional, social, and psychological health of caregivers themselves. Such interventions aim to educate family members about the mental and psychosocial challenges of their caregiving and the potential for serious health sequelae (Given & Sherwood, 2006). A frequently cited goal of such interventions is to persuade family members that caregiving is a difficult job, requiring periodic breaks during which caregiving responsibilities are temporarily transferred to others (Canadian Association for Community Care, 2002).

**Ideographs in caregiving**

Within the health care community, objective measures are typically used to assess the effectiveness of intervention, such as those addressing caregivers’ pathophysiological and practical knowledge. However, these methods are unsuited to describing the process by which professional and family caregiver groups share attitudes and beliefs. The question of how values within a community of caregivers are formed and contested is best accomplished by the tools of communication scholarship. To examine the process by which understandings of caregiving work were negotiated within the community of professional and family caregivers on St. Kitts, I drew upon the theoretical notions of communities articulated by McGee (1980), Condit (1990), and Condit and Lucaites (1993). In particular, Condit’s assertion that communities are constituted by ideological, rather than physical proximity (Condit, 1990) justified approaching family and professional caregivers as a single community, united in negotiating a common framework of values and ideological commitments. Following McGee, Condit and Lucaites, I use the denotation *ideographs* to describe the values expressed in public discourse through familiar, imprecise, emotionally laden terms, e.g., “pro-life” or “choice,” “sovereignty” or “unity” (Condit & Lucaites, 1993; ideographs will be identified in this article by the use of quotation marks). The present study examines how family and professional caregivers come together through a common allegiance to ideographs such as “care,” “comfort,” “family,” and “duty.”

Significantly, Condit and Lucaites note that the “key feature of ideographs is their flexibility as cultural signifiers” (1993, p. xiii). Thus, caregivers and professionals may agree on the desirability of values such as “patient comfort” or “optimal care,” yet discover that this agreement is of little use in the absence of shared definitions of the terms or a unified vision of how to realize them.

Another significant feature of the communicative function of ideographs, McGee asserts, is that they are not found in isolation in a discourse. Complex beliefs are not captured in a single ideograph, but rather in clusters. Ideographs are understood tautologically in relation to other ideographs within their cluster, and speakers manipulate these clusters to advance their persuasive projects (McGee, 1980). For example, although professional and family caregivers both invoke the ideograph of “expert care,” professionals may define the term within the cluster of “doctors,” “tests,” and “hospital.” Family caregivers, in contrast, may define the same ideograph within the cluster of “home,” “familiar surroundings,” or “his own bed.” Each cluster suggests its own course of action for realizing the goal of expert care.
“Respite” as ideograph

The cluster of ideographs examined for this study surrounds the notion of caregiver respite. English-language health literature on family caregiving generally underscores the burdens associated with care, such as depression, social isolation, loss of sleep, poor nutrition, exacerbation of pre-existing health problems, and the development of new ones (Decima Research, 2006; National Family Caregivers Association, 2007; Zarit, Gaugler, & Jarrott, 1999). Restorative time away from the responsibilities of caregiving has become standard advice offered in caregiver support literature (Ingleton, Payne, Nolan, & Carey, 2003). Much research emphasizes practitioners’ concerns about family caregivers’ failure to incorporate adequate respite into their caregiving routines, to take time away from the care recipient (MacDonald & Callery, 2004), or to make effective use of government or institutional respite services (Perry & Bontinen, 2001).

A common finding in quantitative and meta-studies of family caregiving is that family members and even care recipients can benefit from occasional care breaks. Such breaks are to be facilitated through arrangements that “allow caregivers relief or ‘time-out’ from their care commitments, which may be provided on a regular basis or in emergencies” (Jeon, Brodaty, & Chesterson, 2005, p. 298), such as short overnight stays (MacDonald & Callery, 2004) or even extended holidays (Jeon, Brodaty, & Chesterson, 2005).

Another frequent finding in the literature is that caregivers can also experience respite when they achieve a positive, relaxed state of mind. Strang, Koop, and Peden (2002) noted that family caregivers identified respite as a feeling of freedom from worry and responsibility, one not necessarily associated with physical absence from the caregiving setting or the care recipient. In fact, caregivers reported that physical absence from the care recipient often increased rather than decreased worry and concern.

In Canada, the perception of family caregiving as a hard job is further developed by situating the caregiver/worker in the larger discourse of labour. Health Canada and national caregiver advocacy organizations assert that the provision of care to disabled individuals is the responsibility of government organizations, employers, and the community at large, and must not fall completely upon family members (Canadian Caregiver Coalition, 2007). Discursively, the work of caregiving is thus at least partially removed from the family and repositioned within the public sphere. The family caregiver becomes a labourer entitled to compensation in the form of respite and social support services (Decima Research, 2006). Through this definition, family members are subtly changed from directors of their loved ones’ care to clients in their own right.

There has been some criticism of the depiction of caregiving based on a stress-coping/burden model (Ingleton, Payne, Nolan, & Carey, 2003). Researchers have pointed out that framing the work of caregiving as a burden requiring respite suggests that such work is unrewarding as well as difficult. Nolan (2001) further warns that such depictions undermine the abilities of the family caregiver and promote the professional as the source of superior knowledge and skill. A further concern is that the studies promoting time off and time away from care recipients have been conducted in North American and European countries. Studies of family...
Caregiving in other parts of the world suggest that attitudes toward respite are cultural, not universal (Hartley, Ojwang, Baguwemu, Ddamulira, & Chavuta, 2005; Kao & McHugh, 2004). Even within Western democracies, the perceptions of respite and support held by racial and ethnic minorities are poorly studied (Allen-Kelsey, 1998).

Nevertheless, ideographs related to work and stress dominate the professional discussion of family caregiving and find their way into the public discussion as well, as demonstrated in the following admonition to family caregivers from a U.S.-based advocacy group: “Remember to be good to yourself. Love, honor and value yourself. You’re doing a very hard job and you deserve some quality time, just for you” (National Family Caregivers Association, 2007). “Quality time,” “value yourself,” and “hard job” are ideographs that appear frequently both in professional literature and in support materials geared to family caregivers.

Family caregiving on St. Kitts

The Caribbean nation of St. Christopher and Nevis, commonly known as St. Kitts, is the smallest member of the United Nations. It is home to a population of 39,000 inhabitants living on the nation’s two islands, St. Christopher and Nevis. Per capita gross domestic product stands at around US$9,000. Emigrant workers contribute significantly to the nation’s economy; many Kittians make several journeys overseas in the course of their adult life, both for paid labour and for purposes of higher education, as there are no post-secondary institutions on the island (Central Intelligence Agency World Factbook, 2007). As St. Kitts is a member of the British Commonwealth, many students pursuing professional degrees in the health care field enroll in Canadian universities (Chui, 1996). There they are acculturated into the norms and values of Canadian sociomedical culture, including the depiction of family caregiving described in the section above.

The population of St. Kitts is overwhelmingly of African-Caribbean descent. Epidemiologically, the nation’s health services deal with a high endemic incidence of diabetes mellitus, glaucoma, and hypertension (Higginbottom, 2006; Scase & Johnson, 2005). To deal with the population’s health problems, the government passed the Home Healthcare Resolution in 1999, an innovative scheme dedicated to the development of a home-based health care program. Through the program, the government subsidizes patient travel for advanced medical treatment such as chemotherapy or cardiothoracic surgery to more populous islands with advanced care hospitals, primarily Puerto Rico and Jamaica.

The bulk of the nation’s health care resources are committed to a network of neighbourhood family practice clinics that provide comprehensive medical care. This program depends upon a corps of social workers, nurses, and home health officers (henceforth “professionals”) whose primary role is to support the family members who oversee the home-based care of their chronically ill or disabled loved ones (A. Wigley, personal communication, May 17, 2004). Nurses at the local clinic identify patients in need of home care and report these to district social workers, who in turn assess the resources for care available within the home. A home health officer is then assigned to assist in or provide physical care and the administration of medications, and to serve as general liaison with the
the governmental home health program, I arranged interviews with family caregivers and professionals through the St. Kitts Ministry of Community and Social Development. Qualitative, grounded theory methodology was chosen because the object of the study was to examine layers of social relationships in the face of “diversification of life worlds” (Flick, 1998, p. 2). This allowed examination of all participants’ statements as they emerged in discourse, as well as their subsequent coding into larger patterns of meaning through the use of constant comparative analysis (Strauss & Corbin, 1998).

Participants and data collection
The Ministry of Community and Social Development scheduled interviews with 27 caregivers providing primary, full-time care for disabled loved ones in the home and with 20 health care professionals who provided support to the family caregivers. Family caregivers were specifically asked to agree to a visit in their home by a university professor accompanied by several undergraduate students and members of the island health service. In this study, family caregivers ranged from 17 to 93 years of age. Care recipients were between 42 and 103 years old, and were disabled by glaucoma blindness, complications of diabetes, dementia, and cancer, among other chronic ailments and co-morbidities.

Professionals participated in the interviews with family caregivers and were also interviewed in their offices as well as informally while travelling to caregivers’ homes. I was escorted to the homes by the local home health officer accompanied by a group including one or more district social workers, the director of the social work program, and several undergraduate students. Neighbours and other members of the household frequently dropped by to join in the conversation. The number of participants was thus highly variable. All family caregivers agreed to the use of recording equipment, and all conversations were taped. Detailed field notes were made immediately following the interviews. Verbatim transcriptions were made and checked against the original tapes for accuracy. Interviews typically lasted about 90 minutes.

The communicative context of the family caregiver interviews bears special mention. It has been noted that in the qualitative research process, relationships that exist and develop between participants and researchers affect the nature of the data collected (Hamberg & Johansson, 1999). Relationships between participants are especially significant in open-ended interview formats, in which all participants negotiate a number of conversational roles (Cartwright & Limandri, 1997). The ability of participants to shape, contest, and co-construct information was particularly significant in the interviews conducted for this study, due to the fact that all local participants in this study were personally acquainted, in many cases relatives or old friends who shared significant social history. Because of the long-standing and ongoing relationships between participants, discussion was in...
some instances presumably more open and candid than in a structured interview format among strangers. (One family caregiver joked with the director of social work about the impossibility of distorting facts in the presence of acquaintances who knew better: “What don’t you already know about me, my father, and my chickens?”) Conversely, information may have been suppressed as local participants, both family and professional, conspired to present their culture and community in a positive light to an outsider.

The resolution of such questions lies beyond the scope of this project. My claim is that the resulting data do not represent the considered, autonomously formulated opinions of the family and professional caregivers on the subject of their caregiving work. Rather, they present a range of agreements and conflicts related to respite in family caregiving as the topic emerged in natural discourse within a particular community of stakeholders.

**Results**

Transcripts were analyzed using grounded theory methodology (Strauss & Corbin, 1998). In the open stage, themes related to various aspects of caregiving were identified. Then terms related to *respite* were selected. Examining these terms as they appeared within the transcribed discourse revealed differences in the way the terms were used by family and professional caregivers. It was during this stage of data analysis that McGee’s notion of ideographs emerged as a robust explanatory matrix for describing the use of those terms in conversation.

The resulting data suggest that significant differences existed in definitions of the terms relating to respite. Professional caregivers predominantly spoke of caregiving in terms that reflected North American, especially Canadian, social and political conditions, referring to caregiving labour as a service that should be at least partially borne by others, including government organizations. However, professionals also showed awareness and appreciation of local norms that placed caregiving responsibility firmly within the family circle. Similarly, when professionals sought to define respite as periodic physical absence and mental breaks from the care recipient, family members resisted such suggestions. Despite these differences, however, the professional and family caregivers both identified the sharing of caregiving tasks within the extended family as a positive norm in Kittian society.

**Caregiving as social responsibility**

In North American medical literature, caregiving has been described as labour that must not be borne by family members alone, but rightfully shared by the larger community. This attitude can be discerned in the following comments by social workers, all of whom hold master’s degrees from Canadian universities, as they evaluated family caregivers’ use of formal support services:

*Social worker 1:* How do you get [family caregivers] to let go? Some of them, they don’t let anyone else do anything. [Mrs. J, a caregiver] don’t hardly leave the house. Maybe it’s like her control thing.

*Social worker 2:* We can give them service, like take their loved one to the day care centre, or the church can come and they can watch [the care recipients] while they go out and take care of themselves.
While the above comments reflect the view dominant in the professional literature that family caregivers do not take adequate advantage of respite services, the following comment was more in line with locally held definitions of the ideograph “care”:

**Social worker 3:** Here we look at it as a shame if you put your parents in a nursing home. Some, they work too hard and need the help [provided by the nursing home], but others don’t care, and the [care recipient] would be better in the [nursing] home. So nursing homes isn’t so big here.

### Respite as physical absence

Professionals’ comments suggested that they shared the belief commonly held in North America and Great Britain that caregivers benefit from physical separation from the care recipient (MacDonald & Callery, 2004), as in the following example:

**Social worker:** I fear for these [family caregivers], really, especially the elder ones. Their children are off island, they call and say, “How is Daddy, how are you?” and they say, “Oh, fine.” And it’s not fine. I want to say to them, “You come down and care for your father, bring Momma up to you for a while.”

In their interactions with family caregivers, professionals frequently promoted the notion of respite as “time away,” understood as leaving the home or site of their caregiving. Family caregivers, in contrast, offered alternative meanings for the ideograph “time away” that did not include leaving the site of care. In the following exchange, a gentleman caring for his disabled mother offered such an alternative to the social worker’s assertions:

**Social worker:** What do you do for yourself? You need to get away, go someplace, into town, play dominoes.

**Caregiver:** Sometimes, mostly my cousins come here and we drink a beer.

A discussion with a young woman caring for her father in his own home similarly suggested that the professional social worker equated respite with physical separation:

**Social worker:** So where do you go to relax?

**Caregiver:** After I finish with Dad? I go back to my place.

**Nurse:** You take care of your kids [at home].

**Social worker:** That’s not—you need to go to Sandy Beach!

Such exchanges reveal that while professionals promoted time away from the caregiving context as conducive to respite, family caregivers offered an alternative definition, describing relaxation within the family context. A female caregiver stated that she found it more enjoyable to spend time in her garden together with her siblings’ children and her care recipient father than to go to the trouble of organizing a trip into town with friends or to the movies. Another caregiver reported relaxing while babysitting her grandchildren as they played with her care recipient mother after school: “They do for her, plait her hair, play, and I can sit, watch TV.”
Respite as mental break
As noted in a Canadian sample interviewed by Strang, Koop, & Peden (2002), family caregivers remarked that respite could be found not only through physical absence but also through what they termed mental breaks. Both professional and family caregivers interviewed on St. Kitts appeared to share the belief that respite could be achieved through the caregiver’s state of mind.

Professionals tended to associate respite with reflective solitude or time spent alone, as expressed by one nurse regarding a gentleman caring for his mother, bedridden from a stroke: “He goes out and has a cigarette. The smoking’s bad, sure, but it gives him time for his thoughts,” suggesting that the negative effects of smoking were at least in part ameliorated by the health benefits of private reflection. The director of social work noted the benefits of solitude for caregivers: “It helps, I encourage them, sometimes just close your eyes, say your prayers, think of something else, go off for a walk alone. It’s good for them to take that time to tune out.”

However, in contrast to professionals who defined mental breaks in an ideographic cluster that included “solitude” and “time out,” family caregivers described such respite in terms of time spent within a familiar group:

Home health officer: What do you do for recreation and that? You need time for yourself.

Caregiver: Well, I go to my church sometimes. But I’ve eased up on that because of my mom. So they come to me now, the pastor and them.

Similarly:

Interviewer: What do you do to take a mental break, catch up with yourself?

Caregiver: Well, with all of this I am a Christian. That helps me a lot. You have to pray, you have to be with folks, district folks, and I believe that picks you up.

Family caregivers also advanced definitions of mental breaks as pleasant memories and thoughts, not experienced alone but shared with care recipients, as expressed by a middle-aged daughter caring for her mother:

Caregiver: [Mother and I] sit under the tree and sing the old songs, like she taught us when we was little. I forget some, you know, but she can sing them all. So we do that together, you know, to pass the time.

Later in the interview, the daughter related that her mother frequently mistook her for her deceased sister or aunt. She reported that the act of reorienting her mother (“No, Momma, I’m not [your sister]”) frequently provided the women with an opportunity to enjoy reminiscing about departed relatives and friends.

Another caregiver, a grandson who returned from overseas to care for his frail elderly grandmother, described a form of respite in pleasant memories shared with the care recipient:

Caregiver: When I was little, I’d sit up in that tree there... Now, sometimes she says, “Oh, you’re the naughty boy in the tree spitting pits! Watch out I don’t switch you!” Brings me back those memories.
Respite within collective caregiving work

As shown in the interview data, the island’s professional caregivers frequently mirrored values articulated in English-language professional literature when discussing caregiving with family members. In particular, professionals encouraged family members to seek respite through physical and mental time apart from the care recipient through independent actions such as going to the movies, taking walks, or spending time alone. Family members frequently countered such statements with alternative definitions of respite that appeared to reflect local values favouring collective rather than independent action.

All caregivers interviewed expressed admiration for the notion of the family as a collective of care. Family caregivers frequently asserted that they were not alone in their caregiving, but were supported by significant others in the family or community. In the following exchange, a woman identified by professional caregivers as the primary caregiver insisted that the work was equally distributed among all the members of her busy household, a claim that was not consistent with the others’ heavy work schedules outside the home.

*Interviewer:* Are you the person who gives the most care?

*Caregiver:* Hmmm, I don’t know who gives the most. Everybody takes turns, okay? I either clean her bed or give her injections when the others are not here. It’s a sharing thing.

*Interviewer:* So, maybe you have a whole team and you’re the captain of the team?

*Caregiver:* [laughing] No, I’m not the captain. Everybody does their share.

The interviewee presented herself not in the central role of a uniquely devoted caregiver, but as a member of a loving, engaged family. Similarly, another caregiver shared the credit for caregiving work, extending her description of the loving, committed family to include relatives off island, whom she depicted as contributing to the collective effort:

*Caregiver:* My children call every Sunday and talk to me, to Grandma, “What the doctor say? What you need?” They send everything from Costco. That’s such a great relief for me!

*Social worker:* They’re good to you. Have him send the protein powder [recommended by physician as a dietary supplement].

By pointing out that her family members “are good to” the caregiver, the social worker in the example above collaborates in the caregiver’s depiction of an attentive family, actively engaged in the loved one’s care. Throughout the interviews, professional caregivers expressed approval of accounts of collective family caregiving, in which tasks were shared with others within the family circle. On several occasions, professionals even actively assisted family caregivers in constructing such accounts by emphasizing the physical, material, and symbolic participation of others in providing ongoing relief to the primary caregiver. In one home, a social worker pulled me aside to point out photographs of the caregiver’s
family members living abroad, describing their contributions to care (e.g., “This
girl here [in the picture] lives in California and calls our office to ask how things
are going”). At other times, professionals made sure that family involvement was
a matter of record in the interview, as in the following discussion with a man car-
ing for his mother:

*Caregiver*: I give her breakfast, check her blood sugar, get her ready for
the day. My cousin come and give her bath, clean her.

*Home health officer*: And you have your brothers’ help.

*Caregiver*: They’re overseas, but if they’re here, each one help the other.

*Social worker*: But they call and send you things.

*Caregiver*: Ah, yes, sometimes, maybe, yes.

Significantly, in the following exchange, a social worker demonstrated how
local notions of caregiver respite could be brought into line with professional
medical norms:

*Social worker*: Your family is a big help to you.

*Caregiver*: My granddaughter does for me.

*Social worker*: Your daughter [off island] called me to ask how Mother
is. Ask her to call, you know, talk to the doctor, because she’ll understand
better, you know, and can explain you. Then your mind can relax because
you know better what the situation is.

Professionals also acknowledged in private interviews that the cultural norm of
the island was to provide care to family members and to share that work within
the family, not to delegate it to community organizations. As one social worker
noted, this norm was an imperative: “Here we all work together, [even] if you
don’t like it. You work for your family because that’s who you are.”

**Managing incommensurability**

The interactions between professional and family caregivers revealed two distinct
models of caregiving in the home, each associated with a corresponding under-
standing of respite. Family caregivers generally appeared to embrace an integra-
tive model of caregiving, in which the caregiver is fully integrated into the
intimate social context of caring, rarely removed from the care recipient, while
sharing responsibilities with other family members and friends. Respite is found
within the ebb and flow of caregiving routines. This attitude stands in contrast to
the depiction of caregiving presented in professional literature, in which caregiv-
ing is viewed as burdensome, specialized work that requires the caregiver to seek
respite by utilizing public services and periodically withdrawing to seek private
time away from the context of care.

The potential incommensurability of these two positions is succinctly
expressed in the following exchange between family and professional caregivers:

*Interviewer*: Who helps you watch your mom?

*Caregiver*: My sister.
Social worker 1: Yes, she lives across the road here.

Caregiver: [My mother] likes to go over there to see the others.

Social worker 2: So when she goes, do you get your hair done, or what do you do for yourself?

Caregiver: I go with her.

Social worker 2: But you need time for yourself.

Caregiver: Why? I like to go!

Social worker 2: And [your sister’s] girl? She feeling better now?

In this exchange, professionals advanced a specific depiction of respite—that the caregiver will find respite by seeking time to herself, away from her family. The caregiver rejected this advice, or perhaps more precisely, failed to acknowledge it, asserting instead that enjoyable respite is to be found within rather than outside the family circle. The social worker apparently had no response to this assertion and continued the interaction by switching the topic.

Despite their preference for depictions of respite as time away from the care recipient and the responsibilities of caregiving, professionals occasionally suggested ways of integrating their notion of respite with that of family caregivers, for example when encouraging primary caregivers to reduce their stress levels by delegating specific tasks to other family members not regularly involved in caregiving. In this way, professionals could bridge the cultural norms of North America, where they had been trained, and the culture of St. Kitts, where they had been born and raised and were now practising.

This bicultural perspective allowed professionals to acknowledge the difficulties faced by caregivers while simultaneously appreciating the value of family and community participation in caregiving. This awareness positioned them to encourage family caregivers to enlist the help of others in their caregiving work, either by delegating work to other family members during informal social gatherings (e.g., to grandchildren visiting after school or during visits to others’ homes) or by requesting needed supplies and expensive convenience items from relatives off island. Such solutions have the potential to reduce caregiver stress and contribute to respite. Taken together, these data underscore the importance of working within the cultural resources of a community to create culturally acceptable and sustainable solutions to the problem of caregiver respite and support.

Conclusion
As in all qualitative studies, observations made from the present data are not intended to be generalized to larger groups. Nevertheless, the experience of these particular professional and family caregivers underscores the complex role of culture in health care curricula and practice. In North America, professional health care programs emphasize the importance of providing culturally appropriate care to clients (Shaw, 2005). However, as evident in the discourse of the health care professionals interviewed for this study, cultural beliefs are not something that reside only in clients. It is thus essential that students in nursing, social work, and medical programs are also taught to assess their own cultural beliefs and the way
in which these affect their interactions and communication with their clients (Russell & White, 2002).

While sensitization to cultural difference is an important first step, health care professionals need useful ways to actually bridge the cultural gaps encountered in their practice. Professional caregivers observed in this study bridged this gap when they suggested the delegation of caregiving labour within the larger family group (e.g., procurement of convenience items by off-island relatives or recruitment of a relative of the same gender as the care recipient to provide intimate hygiene). When seen through McGee’s theoretical lens, this success can be attributed to the effective merging of the ideographs of “family” and “help from others” into one ideographic cluster of “respite.”

McGee’s concept of ideographs offers an explanation for common instances of miscommunication, such as when professionals and family members agree on the importance of respite while envisioning it very differently. More importantly, ideographs identify common ground upon which stakeholders can negotiate meanings and consensus. Additional research is needed to design and test interventions to facilitate such negotiations, as caregivers seek courses of action that provide for the needs of patients and their loved ones.

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