

Migrant Professional Carers in Four European Regions – A Comparative Exploration of Their Learning Needs

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ABSTRACT

In some European regions, elderly care in homes and in residential care units is taken up to a great extent by migrant paid care, for the most part migrants within Europe. Challenges for elderly healthcare provision and quality have been raised. Our aim in this research was to inquire into the learning needs of professional migrant carers as they perceive them, as a step towards facing these challenges. Drawing on structured interviews with 50 carers in four regions in Europe, conducted between March 2012 and January 2013, the data suggests that there are commonalities that can be addressed. This article presents the general research process and results in Ticino (Switzerland), Liguria (Italy), The Lothians (UK) and the province of Sofia (Bulgaria) with a focus on comparative research outcomes. The analyses suggest that stress and language difficulties are predominant. Training to address these and the recognition of carers as professionals, which training would help support, are suggested.

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Introduction

What is known about this topic?

- There is a need to attend to challenges to social work practice with older people that arises with international migration.
- Stress amongst non-professional family carers and nursing professionals caring for the elderly in hospital wards has been observed.

What this paper adds:

- A comparative study of learning needs of migrant professional carers across European contexts is provided.
- Stress is prevalent among professional carers working in private homes and in residential care units in the four European regions where the research took place.
- Language learning opportunities and support to relieve stress of migrant carers of elderly persons are suggested.

It is widely believed in Italy that caring for the elderly at home is generally better than in a Residential Care Unit (RCU), whether it provides medical assistance or not. However, bedsores are frequent as well as malnutrition for both the frail elderly living at home and those in RCUs. This is most probably due to a lack of knowledge of proper handling techniques, sore prevention strategies and food intake needs. Pressure ulcers have been found in the USA in 2.2% to 23.9% of patients in long-term care and from none to 17.0% in home care (cit. Lyder, 2003). In research conducted in Trieste in 2001 with 2018 patients who were taken in for home nursing (SID), 8.9% had one or more pressure sores. 26.6% had occurred in a hospital ward, 33.3% at home and as little as 2.0% comparatively occurred in an RCU (Sapienza *et al.*, 2002). Constans (2003) found in France that malnutrition too is prevalent in elderly populations. However, screening can “be performed by people who are

not knowledgeable about nutrition but who are properly trained” (Agnello and Amerio, 2011).

In some countries, elderly care has been shifting hands to migrant carers. This has raised concerns for the quality of care in the UK (Cangiano and Shutes, 2010) and in Italy where foreign paid carers are very common (Gagliardi *et al.*, 2012), as well as concerns for the migrant care workers themselves; for example, in Italy (Di Rosa *et al.*, 2012), in Switzerland (Bolzman, 2012) and in the UK (Poinasamy, 2011). As Torres and Lawrence (2012) stated, there is a need to attend to challenges to social work practice with older people that arise with international migration, specifically in Europe, and the increase of migrant care workers.

These findings inspired us to conduct research on what migrant carers themselves have to say about their training needs. The research was designed as an open-ended inquiry into what carers at different stages of their careers and in different regions in Europe perceive as required skills to perform carer duties well. The questions that guided the study covered three time frames: learning needs before beginning work as a carer; present learning needs, and; recommendations for curricula to be included in courses. Each of these three perspectives had an adjacent question about how the carer believes the relevant learning would best be achieved. Interviews were conducted with 50 carers in Ticino (southern Switzerland), Liguria (northern west-coast Italy), the Lothians (Scotland, UK) and the province of Sofia (Bulgaria).

Method

Study Design:

The study employed a qualitative design in which structured interviews were conducted with the participants in the four regions. Interviewers followed a protocol devised for the purpose. Interviews were carried out in the primary language of the region in which

each interview took place. The design was intended to enable interviewees to express their thoughts about their past learning experiences, their present learning needs and their recommendations for carer training.

Descriptive and contextual data pertaining to each interviewee were also collected in the study. The research group in each of the four regions in which the study was carried out conducted the interviews and analysed the narratives of their region. The same methodology was used in each region by each team to enable analyses on a comparative level (Bron, 2008; Reischmann, 2008).

Data Collection and Procedures:

Interviewers followed a protocol which included a guide for the interviewer and the questions to be presented to the interviewee. Together they form the interview schedule. The interview schedule was written in English and then translated into Italian and Bulgarian. The regions in which the interviews were conducted are: Ticino (Italian speaking canton of southern Switzerland), Liguria in Italy, The Lothians in Scotland and the province of Sofia in Bulgaria. One researcher in each of these regions conducted the interviews, analysed the recordings to identify themes and coded the passages using categories and subcategories determined at this stage by the analyser. Categories that were identified by the researchers as prevailing across all regions were used to recode the transcripts for consistency.

Consenting Process, Dates:

Each interview was preceded by an introduction and explanations. The wording to describe the purpose of the interview and provide a background for the research being conducted is given in the schedule, but the interviewer was not required to read it out. The text could be reworded provided that the information was given when the interview began. The introduction included the estimated duration of the interview, the framework within

which the research was being conducted, the research purpose, demand for consent to record the interview and commitment of the research team to confidentiality. In Scotland, an Informed Consent Form was used. Interviews were conducted in Ticino between March and December 2012 (n = 10), in Liguria between March and May 2012 (n = 15), in the Lothians between March 2012 and January 2013 (n = 10) and in Sofia between May 2012 and January 2013 (n = 15).

Analysis Procedures

Interviewers applied coding tags to the transcribed passages in accordance with the themes that had been identified by the research teams and defined during a meeting held in Sofia in October, 2012. The teams met twice again in Paris, first in February and then in April 2013, in order to examine preliminary results and analyses. Analyses were provided by integrating the marked passages and applying code tags using TAMSanalyser (version 4.45b2ahL). Codes were checked for consistency and any ambiguities were discussed with the interviewers who had tagged the transcriptions and solved. Next, the four team members who had interviewed and tagged the passages convened to study overlapping concepts and meanings which might have led to using different tags. Ambiguities were discussed and resolved, different tags with identical meaning were grouped under common names, tags which were applied to subcategories that were too deeply nested were taken out, and a final set of codes for tagging was settled upon. The coders provided exact indications enabling the retagging of the entire set of data files. Data files were supplemented with contextual dates (part A of the interview schedule provided these) and were then analysed for occurrences. Tables with occurrences were then produced in which information from each region could be compared. These tables enabled insight on both regional levels and on a comparative level for research team members on regional levels to further analyse transcripts for meaning and significance.

Research Process and Findings

Teams on regional levels further examined the transcripts of the interviews that they had conducted and produced final coded versions for each narrative as well as a report based on their findings.

Ticino. Interviewees in Ticino were recruited by the University of Applied Sciences in Southern Switzerland. Ages of the 10 participants ranged from 36 to 61. Experience as carers ranged from 8 months to 20 years. While both male subjects were working in a Residential Care Unit (RCU) all female carers were working in private homes (PH) except for one who was unemployed at the time of interview (see Appendix 1. Participants' Characteristics).

Analyses of occurrences of tags relating to the identified themes in the coded interview passages point to two areas: embedded knowledge, including terminology, and to practical knowhow. Personal skills plus technical aides and skills fall under the latter and emerge as areas of concern. Under the category: personal skills, conflict management and concerns around managing the relationship with critically ill patients as well as with their often demanding family members, emerged. Managing interpersonal relations is a stressor. This stressor may be related to other stressors that emerge under the embedded knowledge theme. These are concerns over job security and over social security. To better understand these stressors, they need to be linked to three areas we have identified.

The first area we refer to is professional isolation. Interviewees frequently state feeling anxiety which is due to the host family members being their direct employers while at the same time being part of the care network. A consequence of this is that interviewees tend to avoid consulting external care staff when support from peers may be helpful to solve particular problems. Their employer, if aware of the carer's contact with outside professionals, is feared to interpret this as a weakness or inability to properly care for their relative.

The second area we refer to is professional precariousness. Carers are exposed to a most stressful, precarious and vulnerable situation; a state of continuous uncertainty, as the death of their patient might mean losing their job from one day to the next (see also Wilkinson and Marmot, 2003).

The third area is work-related stress. Although it is not always explicitly defined as such by the interviewees, this type of stress emerges in the category classified under well-being or psychological pressure, primarily as loneliness.

The two types of work settings, RCUs and PHs, affect stress perceptions. The two carers working within an institutional setting (RCUs) seem to have better prospects for professionalisation, e.g., accessing formally recognised higher level training, in comparison to their peers working as carers providing domiciliary care for the elderly (see also Vangelooven *et al.*, 2012). The former benefit through working conditions and labour regulations in several ways. The mingling of private and work life are less likely which, in this context, appears to promote social well-being. The interviewees working as domiciliary carers, on the contrary, can rarely benefit from stable work conditions and hardly enjoy social benefits. In this second type of setting, two key security needs were identified. The first is job security. As it is perceived to be low, there is sometimes a reluctance to express learning needs for fear that this might be perceived as a weakness and hence have negative consequences on the current employment situation. The second is social security. If the patient were to die 'tomorrow', future employment may be a dire prospect. Areas worthy of being addressed to tackle these problems are: information about helpful contacts, self-help groups, associations, job-search networks, etc.

Liguria. Interviewees in Liguria were recruited through the network of an organisation named Studio Taf. Two recruitment routes were used; one for RCU carers, the other for PH carers. For the former, RCUs were contacted directly. For the latter, local

organisations that work with non-Italian nationals, such as trade unions, associations for the elderly and counselling centres were contacted and used as relays. Interviewees in Liguria were aged 25 to 51. All carers had at least secondary education in their native country. One held a degree as a speech therapist; one as an obstetrician. Two held a degree in nursing and had worked as nurses. Carers that were working in PHs did not have specific training in caring, while those working in RCUs had had training either in a course or on the job. Of the 15 interviewees, four were unemployed at the time of interview. The number of years of experience as carers the interviewees had spanned half a year to 12 years (see Appendix 1 for further details). Nine of the interviewed carers did not choose their job, they ‘ended up’ with it. They nevertheless affirm loving their job. Two carers refer to positive emotional involvement; of having been accepted as a family member and of having felt profound sorrow for the death of an elderly person for whom they had cared for for years.

It was very difficult to have the carers talk about their past experiences, except for those working in RCUs and those carers whose careers can be broken down into an earlier period working in PHs and their subsequent work in RCUs. Except for the latter, their years as carers all seemed to run into one. Even if they had worked with more than one elderly person, they tended to generalise their experiences unless they had had specific problems with a family. It is worth noting that these carers were often caring for more than one elderly person at a time and that their experience as carers was often disjointed. There was also some embarrassment to talk about the families they had worked for; as though giving too many details or criticising them also put their own work in bad light.

Carers in Liguria often mention patience, love and intuition as characteristic of the personal skills required as a carer. Six of the Ligurian carers reported that they ‘love’ their occupation and that what is required is being empathic. This is epitomised in the words of Pia, that being a carer requires to “be patient, have a lot of love to give and think that sooner or later we will all become old”. These personal skills are considered by the carers to be

innate. The elderly person's family and the general practitioner (or other medical doctor treating the patient) are considered to be the two main sources for medical knowledge in relation to Activities of Daily Living (ADL). The carer's role is understood as an affectively charged role, providing the necessary assistance under the physician's instruction.

Consequent to this understanding of their roles, there is little awareness of the importance of carer training for ADL of elderly people, such as when the lack of knowledge of techniques can lead to injuring both the elderly person and the carer. This understanding of the carer's role just described is not true for all carers. Some carers distinguish between elderly people who only require practical assistance where common sense is said to be sufficient, and patients who suffer from dementia or other cognitive impairment. In the latter case, carers express a need for training.

Few carers mention a need for training in the use of technical aids and related skills. The main technical aids used are wheelchairs and special beds. While the use of special beds requires minimal training, wheelchair use requires two types of skills: how to manipulate the wheelchair, including wheelchair adjustments for correct posture, and; how to help the person move from or to a bed, a chair, a toilet seat and so on (Garg *et al.*, 1991; Garg and Owen, 1992).

Ligurian carers express that it is important for them to be trained in medication and medical treatment. They also express wanting better co-operation with the patients' families and other healthcare professionals.

Carers in RCUs in Italy are not authorised to perform certain medical routines, such as injections, administer pills or medicate pressure sores. Albeit, PH carers might sometimes find themselves in need to perform some of these operations. Several of the interviewees had had some form of training in these areas. One carer holds a degree in obstetrics, another had asked a relative to teach her and one was trained in a local parish. Parishes often act as a go-between for families to reach carers.

Several Ligurian carers mentioned their wish to attend a recognised training course at some point to become an accredited *Operatore Socio-Sanitario* (social healthcare worker). This credential is the first level for healthcare workers. The motive for this training lies in a belief that “the best training is one which is given through formal lessons by medical doctors and physical therapists” [Sofia].

Although the Ligurian carers have been living in Italy for some years and could understand the interview questions, they were not fluent. This may have prevented some of the carers expressing their deeper thoughts. When language was mentioned in the interviews, it was always to underline how important it is for the interviewee to improve their Italian. Knowledge of Italian is a requirement in order to be employed in an organisation but not for working in PHs. When working in PHs, some of the interviewed carers felt that minimal knowledge of the language is sufficient, at least when beginning to work as a carer, as gestures can be used as well as pointing to objects. A general optimistic view is shared by those who still feel they need to improve their Italian. Their belief is that it is not difficult to improve their Italian language skills and that this will surely happen even without training.

Zoe, one of the Ligurian carers, points to the importance of ‘learning by doing’ and to the importance of cultural differences that need to be understood in order to adapt to the culture of the host country when the carer comes from a foreign one.

Stress when working as a carer was mentioned by four people, two of whom were working in an RCU and two who were unemployed at the time of the interview. Stress was linked to coworkers for one RCU carer.

One RCU carer and one PH carer referred to confrontation with dying and death, bringing to mind the sorrow and mourning involved in the loss of a patient. As Sofia, a PH carer put it, “as if it were a relative” who had passed away.

Lothians. Interviewed participants in the Lothians were recruited through a combination of opportunity and volunteer sampling procedures; that is, by outlining the

research aim and purpose to 12 groups of adult learners studying English for Speakers of Other Languages (ESOL) at West Lothian College's Wellbeing Centre in the central belt of Scotland. Once candidates had expressed interest, they were given an information sheet to read and retain, and were asked to give their consent to participate by signing an informed consent form. All participant materials were stored securely in accordance with relevant legislation and guidance, with all personally identifying information removed to ensure confidentiality.

Ages of the 10 participants ranged from 26 to 44 years. While all had experience of working as carers, this varied from half a year to 12 years. The location in which the interviewees were employed varied too, with a majority working in private care settings (see Appendix 1 for details).

Initial examination of the transcribed interviews highlighted two key thematic areas: issues related to wellbeing or psychological pressure, stress in particular, plus issues related to the challenges of language. The subcategory of 'stress' within the theme of wellbeing or psychological pressure, emerged as not only dominant in the Lothians, compared to the other regions in which the research was conducted, but also as the most dominant subcategory overall in the Lothians. Given that caring for a frail elderly person can have a significant impact on both the physical and emotional health of the carer (Caring Together, 2010), the dominance of stress merited further analysis.

Interviewees often identified aspects of their job or of the care environment as stressors (n = 9). Some examples include having to work long hours. One person mentioned having a 13 hour work shift. Another mentioned the challenges of caring for people with dementia, admitting that it is "difficult to see older people when they are so confused [...] to see people being so unhappy" [Daria]. Yet, these potentially negative and stress-inducing factors were often discussed in positive terms by participants. One interviewee, recalling one day of work, said that "it was a really hard day [...] but] it was a really good day" [Wiola].

Another acknowledged that “it’s a fantastic job to have, to [...] help [...] somebody else” [Szczepan].

Conversely, in some instances, stressors were identified and discussed by interviewees in wholly negative terms. One carer admitted that “it’s a very difficult job” [Marta] while another that “the type of care was quite difficult” [Daria]. Concerning management of one's emotions after the death of a patient, one interviewee said: “I was just left to deal with my feelings” [Crystek].

The second key area highlighted by interviewees was the challenges presented by the language of the host country, in this case English, and more specifically, the difficulties created by the multiplicity of Scottish ‘dialects’ which diverge not only from the form of English studied in ESOL courses, but also from each other across very short geographical distances.

Eight of the 10 carers discussed their arrival in Scotland with low language ability in English. Marianna noted how this affected her life overall, stating that “when I arrive[d] my English [was] poor [...] everything [was] very difficult”. She notes how improving her language skills is a prerequisite when she states “I would like [to] help [...] elderly people [...] maybe later when I can improve my English”.

Similarly, some carers noted the lack of employer response to their job applications. This for Justyna was assumed to be: “because at first [a] very big problem for [me] was language”. She had sent in many applications and CVs with no results. Other carers discussed their feelings of being judged because of their language skills. As Daria put it, one “cannot say what [one] wish[es] to say because of this barrier”. She continues to state: “because my language was not good – people think that you’re stupid”.

Interviewees in some cases also commented on the additional difficulties presented by multiple Scottish ‘dialects’. According to Andrzej “...local dialect, is very difficult in the beginning.” One carer suggested that “dialect is a bigger problem than language” [Daria].

Other carers commented not only on the prevalence and challenge of local dialects, but also the existence of ‘generational dialects’. As Andrzej describes it, it is a problem for “someone who is caring [for] older people [as] they talk in a different language, they have specific words which some younger people never use now.”

Despite the prevalence of language as a key challenge, a divergence of opinion as to how best to address this surfaced. Some interviewees suggested the crucial importance of learning the language of the country prior to migrating to it, while others asserted that dialects cannot be learned in advance.

Carers in the Lothians outlined language, and more specifically the understanding of different dialects, as a difficulty that is preventing them from gaining appropriate or indeed any employment. However, many of the participants appeared resigned to the fact that language and dialects were a challenge that could not be overcome by prior training.

The key themes that emerged from the interviewees in the Lothians highlighted the need to further explore what carers mean when they describe ‘stress’ in order to define appropriate learning or training provision. Similarly, there is an urgent need to further consider how to address the challenges that Scottish ‘dialects’ can present. For example, there may be a need to adjust curricula to begin to raise awareness amongst migrant carers of the existence of differing geographical and generational dialects.

Sofia. Bulgaria became a member of the European Union (EU) in 2007. Many Bulgarian women who were then able to emigrate to other EU member states moved mainly to Greece, Italy and Spain, to work as carers in order to provide a better life for their families, i.e., better income. There are towns in the country which have seen their social structure utterly changed after women massively moved to work as carers abroad. In these towns, the men were left behind to care for the children. The documentary by Komandarev depicts these social changes powerfully. According to Zahova (2013), Bulgarian migrant workers

find work through acquaintances who provide contact with host families, but this is not always the case for Badante (carer) women, as our study too shows. Approximately half of the carers we interviewed (n = 7) found jobs through acquaintances. Basic training as carers is sometimes provided by several job agencies. Training duration is between one and two days.

This research provided an opportunity to learn from the experience of Bulgarian carers, now retired for the most part, who have returned and are living in the province of Sofia. Interviewees were recruited through a local organisation named Znanie - Centre for Vocational Training, in Sofia. The organisation contacted agencies that send carers abroad to request to be put in touch with carers. This was not met with much success. Although 'everyone knows someone in Bulgaria who works as a carer for the elderly somewhere abroad', finding carers willing to talk about their experiences was not an easy task. The main reason seemed to come from fear that the image of success and wealth which they had built for themselves after returning to Bulgaria would be spoiled. These carers were perhaps dismayed that an interview may deteriorate the myth construed around these migrations – a myth concealing the hardships involved in torn apart families.

Ages of the participants ranged from 25 to 75. Of the 15 interviewees, all but four were retired. Two worked in RCUs, one worked as a social assistant and one was unemployed. The primary language of all 15 carers was Bulgarian, although some spoke other languages too.

In all, eight other languages were spoken by five of the carers, one of whom spoke four other languages apart for Bulgarian. The number of years of experience as carers the interviewees had, spanned from three months to 13 years (see Appendix 1 for further details).

To the Bulgarian carers, personal skills were the most important skills required of a carer. "In this work you are not only a cook and a cleaner, you have to make them smile, to take pain away. To give, but do not take" [Svetlana]. Personal characteristics are put

forward as caring is not professionalised in Bulgaria. Only one of the women we talked to had taken a professional training course in Bulgaria. Others had found jobs on their own, relying on their life experience and the tradition in Bulgaria of caring for one's elderly family members. As Victoria put it, "We have all taken care of our own parents. This is something familiar to us". Personal characteristics that were mentioned included: patience, flexibility and diligence.

Bulgarian carers often spoke of their practical knowhow in carrying out ADL. These activities were not thought of as requiring particular training. Recalling her experience, Diana said: "We would go for walks. To do the cleaning and the washing I didn't think I needed special training."

The economic crisis, low income and an incapacity for the parents to provide for the household were often mentioned as motivators to take up work as a carer. Dilyana put it in these terms: "It's very hard when you have no choice. Many times I wanted to catch the bus [back home] but I knew I should help my family." Stress buildup could result as some continued working under illegal conditions, unaware of their rights. These circumstances do not leave much room to consider training as a means to pursue professionalisation. Ten of the Bulgarian carers mentioned that their jobs were thought of as temporary; the result of economic needs. The absence of orientation towards professionalisation leads to a common psychological discomfort that we observed when conducting the interviews with the Bulgarian carers. The discomfort at issue results from perceiving oneself as competent within one's professional role as a carer and the lack of regard by the patient and his or her family. "Be prepared that they will underestimate you" [Elena]. Frustration may result from the contrast between one's previous experience in caring for a close relative, in which the carer determines what, how and when to provide it, and the need to yield to the whims of the patron and the rules of the house when caring for a foreigner in that person's home. Not

being recognised as a 'professional' disempowers the carer and may subject her to the inconsiderate authority of the employer's household.

Differences between the carer's culture and the culture of the host country, as well as lack of prior knowledge of the language of the host country, are other strains on the Bulgarian carer working abroad. All Bulgarian carers mentioned that learning a new language, isolation and loneliness were elements for which they were not prepared.

Comparative Findings

The analyses that were conducted at regional levels point to two areas that emerged in all four regions. These areas of interest are concerns with language and concerns related to psychological factors that play on varying degrees of well-being. These two areas prompted us to further comparatively analyse the coded interview transcriptions. Before addressing issues around language, we suggest that varying degrees of well-being are sometimes expressed as stress when referring to a degraded state of the comfort that characterises it. A state in which anxiety is the result of insecurity, e.g. job insecurity in Ticino, or dependency on livelihood in the Sofia interviews. The causes of these anxieties reveal forms of submission not untypical of subordination or perhaps even servitude. Difficulties related to communication, language issues in particular, do not appear as causing anxiety. It is therefore acceptable to separate language related areas of concern from well-being issues.

A comparison of enunciation of language related needs reveals that learning the language, primarily through experience, is important for Ligurian and Lothian carers. For the Sofia carers, language difficulties were something they were not prepared for when they left to work as carers abroad. Ticino carers did not mention difficulties with language, but while one carer mentioned the importance of learning the language and the culture before starting on a job, many mentioned the importance of knowing the local language (n = 5).

Well-being is the second area that emerges in all regional contexts. On the one hand, emotional involvement was expressed by carers primarily in Sofia (four carers) and by one carer in Liguria, as well as enjoyment and pleasure which were expressed in the Lothians and in Liguria by three carers in each of these regions. On the other hand, loneliness is expressed in Bulgaria where emotional strains are high. Three of the Sofia carers express feeling imprisoned. Diana recalls: "They sent me at the beginning with a completely blind woman. Two and a half months I was a prisoner. Some days they did not give me bread [...] There must be some regulations; contracting. All you have are two hours free." Six Ticino carers also expressed isolation, though far from the extreme restrictions that some of the Sofia accounts reveal. Also worth noting is that the Ticino carers' narratives, in addition to accounting for isolation, do not reveal emotional involvement or pleasure. This, in combination with the isolation felt, could point to suffering, though contextual specifics may be inhibiting the expression of emotional involvement or they may be overwhelmed by other aspects.

Stress has emerged in all regions where carers were interviewed. By far the most frequent expression of stress came from the Lothian carers (six carers). Contributing to stress was a feeling of being on one's own while having to deal with painful emotions such as the sadness of seeing old persons affected by the degenerative affliction typical of those being cared for. As Daria suggested, it would be helpful if carers "knew each other a little bit more from different places of work, then have coffee together and talk about issues, about people [they] support or care for". A cause for vexation that arose in three of the Lothian narratives is concerned with recognition and consideration, on the one hand for the carer as a person of equal standing and worthiness; and on the other, for the profession as a whole. Similar grievances were expressed by the Sofia carers.

Observing differences between carers in the four regions, Ticino carers and Sofia carers were most concerned with job precariousness and securing their livelihood. This was also the case for the carers in Liguria but to a lesser extent.

Conflict management and concerns around managing the relationship with critically ill patients emerged in Ticino. Concerning patients afflicted by incapacitating illness, Ligurian carers relied on the guidance of the family physician or on other qualified medical staff. This did not emerge in the other regions.

A comparison of required skills carers expressed, including needs for training, uncovered different areas ranging from the patience one needs as a carer in managing frustration due to difficult communication with the elderly person, to wanting a better understanding of the physiological phenomena and cognitive implications of forms of dementia. Patience, trying to understand what is going on in the patient's mind, trying to understand reasons for the elderly person's anger or unwillingness, etc., emerged as skills that the carers possessed after having gained them through experience. It is inferred through the interviews that developing these skills could be facilitated through training.

Discussion

Lack of fluency in Italian meant that sometimes the Ligurian carers could not respond in depth to some of the questions. Except for the Sofia carers and one Ligurian, the interviewees' mother tongue was not the language used for the interview. There is good reason for concern, perhaps not in regards to understanding the questions as these were rephrased if necessary, but in regards to the ability for interviewees to express their more complex thoughts or ideas.

In spite of that, the material collected did offer a rich basis of information that once analysed for meaning and for prevalence enabled recognising commonalities and specifics in the various contexts. The most prevalent commonalities concern forms of stress, ill-being

and on some occasions, actual suffering. These were due to work conditions for some carers who were not only hardly recognised for their competences but also had to forgo legal recognition at times. For many, a sense of isolation and lack of support to deal with distress was felt.

Support could come from peers through meetings where carers could share their experiences. This type of peer support was suggested by Daria, one of the Lothian carers.

In addition to feeling helplessness as a result of conditions under which some of the carers were working, the fact of recognising oneself as possessing weak language skills added to carers' powerlessness. The analysed interviews point to these weaknesses in claiming one's due recognition as a professional. Training and certification would be a step to support recognition for these carers.

Yet, technical ability, technical aids knowhow and knowledge related to physical aspects of health and nutrition, which had inspired the researchers' involvement at the outset, were left unanswered. The methodological choice that was made for this research was intended to avoid distorting the importance of carers' needs which may have resulted if the research had been focused on aspects that were primarily the researchers' concerns. In so doing, it has brought forth carers' perceptions and concerns. Other methods may have targeted the specific aspects of our initial questions, but they would have left out the concerns of foremost importance for the carers themselves.

According to Lund (2005) "Being able to cope with the stress of being a caregiver is part of the art of caregiving." Although the kind of stress that we have uncovered in this study differs from the stress and burden felt by non-professional carers, family members for the most part (Chenier, 1997; Lund, 2005) or by professional carers when faced with psychiatric disorder symptoms (Cocco *et al.*, 2003; Wood *et al.*, 1999), stress emerges for these migrant professional carers as a major concern too.

In respect to our findings, one could conclude from the absence of concerns with technical and physical healthcare aspects, that carers are simply unaware of their importance, therefore training in these areas is in effect needed, though this would be an imputation which remains hypothetical. It is also possible that these concerns are overshadowed by the more pressing concerns expressed. Two conclusions can thus be drawn: that this research is a first step in exploring carers learning needs and will require follow-up studies, and; that the needs that emerge through this study concerning language mastery and well-being are of prime importance to carers. These areas of concern can be addressed, at least to some extent, through training.

Regarding the first conclusion, follow-up research should enable addressing the hypothesis that other more technically-oriented and physical healthcare centred training may be required. New research could also inquire into other specific training needs. However, establishing means to help recognition of the profession, offering support to overcome isolation and empowering carers, are some directions for action that can be taken to relieve carers. There is no doubt that tackling these through training and other professional learning opportunities should improve both carers and cared-for elderly peoples' well-being.

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Table 1: Participants' Characteristics

Region	Subj. N	Age M (SD)	F - M ¹ N	Years	PH - RCU	Primary Language ³ (N)
				Experience M (SD)	- Other ² N	
Ticino	10	46.50 (8.15)	8 - 2	8.96 (6.29)	7 - 2 - 1	Polish (6), Romanian (1), Macedonian (1), Serbian (1), Croat (1)
Liguria	15	41.73 (8.82)	14 - 1	5.63 (3.67)	3 - 8 - 4	Spanish (5), Romanian (4), Polish (3), Italian (1), Arabic (1), Russian (1)
Lothians	10	32.1 (5.82)	7 - 3	4.40 (3.40)	6 - 2 - 2	Polish (6), Czech (1), French (1), Hungarian (1), Russian (1)
Sofia	15	60.40 (13.68)	15 - 0	5.73 (3.55)	0 - 2 - 13	Bulgarian (15)

1. Female - Male
2. Work location type or situation at the time of interview: PH = Private Home, RCU = Residential Care Unit.
3. The primary language spoken was defined in the interview schedule as the first of the “main language(s) that you use(d) when talking with your parents”.