TEMPORAL ASPECTS OF MEXICAN AMERICAN INTERGENERATIONAL CAREGIVING

by

Socorro Escandón Dominguez

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ABSTRACT

**Problem and Background**: Caregiving for elderly family members can be viewed as a part of and extension of supportive behaviors
between individuals. Consequently, there are cultural undertones to caregiving and what is supportive in one culture may not be in another. Mexican American caregiving has not been well studied; however, Mexican Americans are reported to be more likely to use family as resource for solving problems than non-Hispanic whites.

**Purpose:** Guided by caregiving framework developed by Bowers (1987), Wilson (1989) and Nolan et al. (1995, 1996, & 1997) this study employed grounded theory to formulate a conceptual model of intergenerational caregiving among Mexican American families focusing on characteristics of the temporal axis which defines caregiving in terms of 1) family structure or generational attitudes (historical time); 2) what and how shared understandings with elders and among family members influence who assumes the caregiver role and when (kin time); 3) how entry into the caregiving role affects the entire family (intergenerational development time); and 4) how entry into the caregiving role affects the caregivers’ peer relationships (peer time). This study also builds theory about how acculturation influences family caregiving.

**Design, Methods:** This exploratory study was guided by grounded theory methodology where interviews were taped and analyzed using grounded theory’s constant comparative method of analysis.

**Sample:** The sample consisted of Mexican American caregivers (n=10) of various generations over the age of 21 who provided at least one intermittent service (without pay at least once a month) to an elder, related through consanguinal or acquired kinship ties.
Results: Grounded theory of Role Acceptance comprised of four phases: 1) Introduction: Early Caregiving Experiences; 2) Role Reconciliation; 3) Role Imprint; and 4) Providing/Projecting Care.

Significance: This study provides a Mexican American intergenerational caregiving model that can be utilized to study varied generations of Mexican American caregivers. It also provides a framework for comparison with other groups of caregivers. Results of this study also inform health professionals about ways in which Mexican American caregivers view caregiving. This information has potential to increase cultural competence in delivery of health care to elders and their families.
CHAPTER ONE
THE RESEARCH PROBLEM

This exploratory study used the grounded theory method to focus on traditional Mexican American family values and their effect on a temporal axis of intergenerational caregiving. The temporal axis describes the dynamic progressive process, over time, of caregiving as a part of and an extension of a range of supportive behaviors between individuals, with cultural undertones, where plans and decisions made by caregivers are not always based on observable tasks but may have important consequences for all lives involved (Nolan, Grant, & Keady, 1996; Nolan, Keady & Grant, 1995; Bowers, 1987; Wilson, 1989). Burton and Sorenson (1993) define the temporal axis according to five dimensions of time—historical time, kin time, peer time, intergenerational developmental time, and social service time. These five dimensions will be discussed in more detail later in this chapter. The temporal axis is one of several axes described in the Kahana, Kahana, Johnson, Hammond and Kercher (1994) paradigm for models of caregiving and caregiving research. Although some researchers have studied and documented family care, as defined by meaning or purpose rather than by the nature of the behavior or task (Bowers, 1987; Wilson 1989a; Wilson, 1989b), no one has
explored the influence of Mexican American family values on the temporal axis of caregiving.

The care of the elderly continues to be of increasing importance. Because past generations did not live as long as people do today, family support has become essential in caring for the elderly with functional impairments, in their disabled years (Miller, 1981). Nolan, Grant, and Keady (1996) suggest that prior to the 1980s, the literature on caring or caregiving was not applied to the interactions between families and those cared for. Nolan and colleagues (1996) summarize the caregiving literature since that time to contain seven major themes, which summarize much of what is known about family caregiving. These themes are: 1) the burden of caring; 2) the tasks or physical aspects of caring; 3) most work on the concept of burden has been done from a quantitative approach; 4) most studies have focused on the caregiver, not the care receiver; 5) the emphasis has been on the negative versus the positive aspects of care; 6) the way in which caregivers cope with and/or manage the situation is poorly understood; and 7) the published literature tends to be limited to either the United States or the United Kingdom. Over time, the literature on caregiving had grown in both volume and sophistication, but despite this, George (1994) believes that much remains to be learned about caregiving at both conceptual and empirical levels. This study has the potential to provide a Mexican
American intergenerational caregiving model from the temporal axis—a model that could be utilized to study Mexican American caregivers of varied generations, acculturation and assimilation levels, as well as provide a means for comparison with other groups.

The caregiving literature covers a wide range of topics but can be conceptualized in the following two ways. First is a focus on the content of caregiving, which is characterized by objective measures which include specific tasks involved in providing care; tasks such as bathing, transporting, grooming, preparing meals, providing financial assistance, etc, often referred to as activities of daily living (Bowers, 1987; Given & Given, 1991; Montgomery, Gonyea, & Hooyman, 1985). The second conceptualization of caregiving focuses on purpose, which is characterized by indirect activities. These activities focus attention on subjective measures that relate to planning, organizing, monitoring, supervising and decision making that may have important consequences for the entire family. This study employs the second conceptualization.

Caregiving can be viewed as a part of and an extension of supportive behaviors between individuals. Consequently, there are cultural undertones to caregiving and what is supportive in one culture may not be in another. Mexican American caregiving has not been well studied; however, Mexican Americans are reported to be more likely to use
family as a resource for solving problems than non Hispanic whites (Vega, 1995). Latinos as a whole are known to migrate towards kin networks, maintaining family ties as a “coveted obligation” (Mindel, 1980). According to Vega, the style of the Latino family’s behavioral manifestation known as familism is “qualitatively distinct from the behavior of non-Hispanic Whites” (p. 7). Because Mexican American families worry together, celebrate together, and help each other in times of crises, in order to understand and support caregivers, it is important to determine when family life ends and informal caregiving begins. The idea for this study originated from the need to know how culture affects an expanded paradigm of caregiving in which caregiving is defined by purpose rather than by task.

An expanded paradigm for family caregiving requires consideration of the “personal, social, and temporal contexts of caregiving” (Kahana et al, 1994, p. 3). Figure 1.1 provides an overview of this paradigm which addresses the who (the spatial axis), the when (the temporal axis), and the what (the transactional axis) of caregiving on an individual and a group level. The columns represent the axes of the caregiving paradigm and the rows represent different levels of aggregation. Kahana and colleagues propose three axes as a possible road map for understanding caregiving at an individual or personal level and at a group or social level. The temporal axis provides a way of expanding the
view of caregiving so it is embedded in the life experiences of individuals and groups.

For the purposes of this study, the temporal (when) axis provides a framework to explore Mexican American intergenerational family caregiving as it relates to informal caregiving, a process embedded in the structure or institution of the family. According to Kahana and colleagues (1994), the temporal (when) axis provides a way for expanding an understanding of time within the caregiving experience from a focus on the length of illness or duration of caregiving to what Burton and Sorenson (1993) define five dimensions of the temporal axis. These are 1) historical time, which focuses on “demographic” changes in family structure or “generational” attitudes about caregiving; 2) kin time which encompasses “shared understandings among family members” regarding who and when certain family members assume the caregiving role; 3) peer time which involves the “patterns of temporal synchronicity” in which friends or colleagues of the caregiver engage in caregiving roles in their own families; 4) intergenerational developmental time which relates to the “timing of entry” into the caregiver role; and 5) social service time which involves the “clock hours” when social service agencies offer support to care providers (p. 48).

The first four relate to personal caregiving at an individual level, while the fifth relates to social
caregiving at a group or system level. This study focused on the first four dimensions of time within the temporal axis of the caregiving paradigm (Figure 1.1).
**Figure 1.1: Spatial, Temporal, and Transactional Dimensions of the Caregiving Paradigm.**
Statement of Problem

As individuals age, the risk increases for physiological and psychological dysfunction. The consequence of such dysfunctions is the loss of independence with increased need for provision of formal or informal care. Cuthbert (2001) reports that 34% of Hispanics provide care for their aging parents, in-laws, or other relatives. Researchers are being challenged to study Mexican American caregiving because 1) demographics suggest projections that the number of minority elders will continue to rise; 2) family care within Mexican American families is viewed differently than in non-Hispanic white families; and 3) relatively little has been documented about caregiving within Mexican American families. Each of these areas is discussed in the following section.

Care of the Elderly

In the year 2000, the number of individuals 65 years and older increased from 1.3 million in 1900 to 35 million representing 12.4% of the United States population. Persons aged 100 years or more numbered 50,545 in 2000, a 35% increase from 1990. The older population is expected to continue to grow and mushroom between the years 2010 and 2030 as the "baby boomers" reach the age of 65. Minority populations are projected to represent 25.4% of the elderly in 2030. Non-Hispanic Whites are expected to increase by
81%, with Hispanics increasing by 328%; African-Americans by 131%, American Indians, Eskimos by 147%; and Asians and Pacific Islanders by 285%. Limitations on daily activities as well as chronic conditions increase with age. Many older persons have at least one chronic condition and many have multiple conditions. In the year 2000, 27% of elders assessed their health as fair or poor with African-Americans elders at 41.6% and Hispanic elders at 35.1% versus non-Hispanic white elders at 26% (Profile of Older Americans: 2002). No doubt the number of elders with chronic conditions will also increase in number, and they will require different levels of caregiving throughout their lifespan. The focus of this research provides additional information to assist in the development of support programs for care of the elderly in the Mexican American population.

Family Care in Mexican Americans

The anticipated demographic changes, especially for Hispanics, present a critical challenge for informal family caregivers. Latinos, regardless of their national origin, report a strong commitment to family and are known to rely on family as the primary source of identity and support in times of crisis (Hurtado, 1995; Rothman, Gant, & Hnat, 1985). Keefe and Padilla (1987), state that certain dimensions of familism such as perceiving a high level of family support and desire for geographical closeness to
their families versus using family members as role models are strong regardless of acculturation levels. Keefe (1984) notes that Mexican Americans in contrast to Anglos are more apt to agree that aged family members should be cared for by family as opposed to care by others in a nursing home setting. The research on eldercare within Mexican American families is extremely limited. Further as speculation that family caregiving among Hispanics is growing increasingly difficult due to economic pressures that demand women in the workforce; this study was designed to increase the understanding of how Mexican Americans define caregiving from a temporal axis point of view; when caregiving decisions are made; and how these decisions are carried out in the care of elders.

Literature in Mexican American Caregiving

Although there is “substantial literature on informal care of the elderly, the data have been primarily from white, middle-class populations...one reason for the specific neglect of Hispanic elders has been the relatively small size of the population... however, this situation is rapidly changing” (Jolicoeur & Madden, 2002, pp. 107-108). Connell and Gibson (1997) reviewed and analyzed empirical research published since 1985 that examined the impact of
race, culture, and/or ethnicity on the dementia caregiving experience. They reported that ten of the twelve studies were comparisons between Black and non-Hispanic caregivers; one involved Black and Hispanic caregivers; and only one focused on non-Hispanic White and Hispanic caregivers (Mintzer, Rubert, Loewenstein, Gamez, Millor, Quinteros, Flores, Miller, Rainerman, & Elsdorfer, 1992). A literature search was done on MEDLINE, PSYCHINFO, CINAHL, and HEALTHSTAR, using key words of caregiving, elder caregivers, and Mexican Americans. A total of seven articles were obtained, and will be discussed in detail later in chapter two. With increased longevity, and the projected increase in Mexican American elders, as well as their need for care due to chronic illness, the issue of intergenerational or familial support of Mexican American elders while beneficial to society as a whole, can be quite detrimental to the caregiver. Research is needed to understand the issues, to design appropriate nursing interventions that support caregivers, and to formulate policy that can support caregivers.

Background

In the following section, the Latino/Hispanic population composition is first discussed, followed by a summary of the past history of Mexican Americans in the United States.
The terms Latino and Hispanic may be useful as political and census identifiers, but they disguise the diversity of the population as a whole. The category Hispanic was “created by federal statisticians to provide data on people of Mexican, Cuban, Puerto Rican, and other Hispanic origins in the US. There is no precise definition of group membership, and Latinos do not agree among themselves on an appropriate group label” (Massey, Zambrana, & Bell, 1995, p. 193). The Latino/Hispanic population is composed of diverse groups of people of Mexican, Cuban, Puerto Rican, Dominican, Colombian, Salvadoran, and other extractions. In theory, all those who can trace their origins to an area originally colonized by Spain, are classified as Hispanics. In reality, this does not describe any common traits. “The history of migration, and later immigration of Mexicans to the United States has affected and continues to affect the social, economic, and political life of the Mexican/Mexican-American population in the United States” (Massey, Zambrana, & Bell, p. 193). For the purposes of this discussion, individuals born in the United States of Mexican decent from any generation will be referred to as Mexican Americans or Chicanos.

Review of some past history of the Mexican Americans in the United States is helpful to better understand the nature of acculturation and its effects on the Mexican American population. The Hispanic heritage of the Southwest has two
parts: the Spanish and the Mexican Indian. The Spanish
conquistadors imposed their culture on the peoples in the
Americas. The children of Spanish and Indian marriages were
called Mestizos. They were a genetic mixture of European
Spanish and the New World Indian. Between 1528 and 1602,
the Spaniards explored the borderlands from Galveston to San
Diego; from Sonora to Santa Fe; from the west coast of
Mexico to Monterey. By the 1630s, the Spaniards had managed
to establish a series of settlements and had successfully
transplanted their language, their religion, and many of
their institutions. By the 1800s, Meztizos outnumbered the
Spanish, eventually becoming the dominant group in Mexico.
This dominant group, at one time claiming identity to either
the Indian or the Spanish claimed the unique identity of
Mexicano by the 1800s. Pureblooded Spanish people born in
Mexico eventually disappeared through intermarriage. The
Spanish heritage with the Mexican-Indian heritage, as its
secular counterpart, became enshrined throughout the
Southwest, and its imprint on the borderlands is clear. The
names of three states in the region are Spanish in origin:
California, Nevada, and Colorado, as well as names of
rivers, mountains, towns and cities (McWilliams, 1975). The
Spanish language is now spoken by upwards of 30 million
people in the United States (Census 2000).

The Guadalupe Hidalgo Treaty of 1848 ceded to the
United States a territory that included California, Arizona,
New Mexico and parts of Texas. When Mexicans migrated to southwestern United States after this treaty, “psychologically they did not immigrate, but rather migrated from one area of Mexican culture to another” (Meier, 1990, p.309). The treaty provided specific guarantees that allowed the people the right to retain their language, religion, and culture. If they remained within this territory, they would become U. S. citizens within one year. There were no mechanisms for the integration of the natives as a group into US culture. In fact, for New Mexico and Arizona statehood was not ratified until some 64 years following the promise outlined in the treaty. The fact that statehood was delayed allowed the retardation of the assimilation process for the population, thereby encouraging the survival of the Mexican cultural influences. This cultural connection and contact, plus the relative ease of travel back and forth to Mexico, resulted in commitment to the permanency of the move to the United States in less final terms than that of European immigrants (McWilliams, 1975).

The Mexican Revolution in the 1910s is attributed as the reason that Mexicans, mainly refugees, began migrating to the United States. During the First World War, the immigrants were mostly small farm operators, tradesmen, and craftsmen who came for economic reasons. “Because of their numbers, they established a majority of the present-day
Mexican-American communities and significantly shaped Chicano culture" (Meier, 1990, p.310). During the years of World War II, the immigrants came solely because of the perception of better economic benefits; a perception that continues to this day. Today many Mexican-Americans have relatives among the recent immigrants, they share language, culture, occupations, parts of their histories, and often live together in the barrio. Their culture is often characterized by values such as *familismo*, a strong sense of family; and *personalismo*, a focus on relationships rather than on tasks (Vega, 1995). It has been important to describe the historical experiences of Mexican Americans in order to understand more clearly how their heritage and the process of acculturation affect families and their care of the elderly. These cultural values and history behind their development undoubtedly affect the way caregiving is viewed, conceptualized and performed. Other factors affecting the caregiving view are the level of acculturation, assimilation and ethnic identity.

**Acculturation, Assimilation and Ethnic Identity**

The process of adaptation by people of Mexican descent to life in the United States has been discussed in terms of changes in ethnic identity. Because “family structure is essential to understanding the three processes of culture change (acculturation, assimilation, and ethnic
identification)” (Keefe & Padilla, 1987, p.129), a discussion of ethnic identity as well as differentiation between acculturation and assimilation is essential in order to define and understand the effects, positive and/or negative, of culture on a caregiving model. According to Triandis (1994), “culture includes traditions that tell what has worked in the past.” He believes that culture is the way people look at their environment and that their unstated assumptions define how their world is and how they should act. Addressing the question of what cultural values guide the Mexican American caregiver in the caregiving experience is vital.

Acculturation and Assimilation

The classic definition of acculturation often cited is that by Redfield, Linton, and Herskovits (1936), who define acculturation as:

“those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups...[it] is to be distinguished from culture change, of which it is, but one aspect, and assimilation, which is at times a phase of acculturation. It is also to be differentiated from diffusion, which...is not only a phenomenon which
frequently takes place... but also constitutes only one aspect of the process of acculturation" (p.149-150).

Acculturation is a multidimensional and complex phenomenon and appears in the literature as early as 1880 (Berry, 1980). This dimensionality and complexity exists at various levels. Among Mexican Americans, there is complexity in the bi-directionality that acculturation may adopt. Acculturation “requires direct contact in order to occur and is not contingent on a change in values” (Teske & Nelson 1974, p. 358). It may take the direction of strengthening barrio behavior, which refers to the maintenance of social relations based primarily on family ties, and/or occur in the direction of the Anglo majority (Domino & Acosta, 1987; Keefe & Padilla, 1987).

Teske and Nelson (1974) contend that although assimilation and acculturation have “been treated as one and the same or, at times, as stages of one another” (p.358), these two are separate processes. Assimilation requires “both a positive orientation toward, and identification with, the out-group on the part of the assimilating individual or group... [it] comprises ...an internal change...involves changes in values” (p.361). Johnston (1963) proposes two components to assimilation. The first is that of external assimilation when an individual accepts in an outward manner certain aspects of the culture such as
language. The second is in terms of subjective assimilation when the individual psychologically wishes to identify with the new culture. In this manner, external assimilation can exist without subjective assimilation, but not vice versa. In contrast, acculturation is an acceptance that does not require a change of values.

Models of acculturation and assimilation have been used to explain the process of adaptation to life in the United States, which has often been called Americanization. The single-continuum model assumes the gradual replacement of traditional host cultural traits with Anglo American traits. The two-culture matrix is one where two cultures are treated independently. The third model is one of multidimensionality that recognizes the acceptance of new cultural traits with the loss of traditional cultural traits, but varies from trait to trait (Keefe & Padilla, 1987). Examples of cultural traits are “language usage, dress customs, technological necessities, values, sentiments, and attitudes on various socialization practices” (Mendoza & Martinez, 1981, p.73) to name a few. Some characteristics are compatible cross-culturally, such as speaking both English and Spanish; eating Mexican and Anglo-American foods and have Anglo and Mexican friends. On the other hand, “cultural patterns that require competitive as opposed to cooperative life-styles or extended rather than nuclear family ties are structurally bipolar or
mutually exclusive since the acquisition of one cultural style requires the exclusion of the other” (Mendoza & Martinez, p. 73).

Ethnicity

Social scientists in the first part of the 20th century believed that ethnicity would eventually disappear in urban, industrial societies, including the United States. They associated urbanism with increasing individualism, growing alienation in a mass society, greater geographic and socioeconomic mobility, and the loss of community, all of which would contribute to the decline of meaningful ties to any particular group. Studies, however, found the opposite. Ethnicity does not disappear; it persists (Keefe & Padilla, 1987). America was founded on the premise of equality. This requires allegiance to a national identity, which fosters the myth of the “melting pot”. According to McGoldrick (1986), the notion that distinctions among people are unimportant has not been actualized, in fact “we have not melted” (p. 3).

It is commonly accepted, among researchers, that ethnic identity is a multidimensional construct involving “ethnic feelings, attitudes, knowledge, and behaviors” (Phinney, 1995, p.58). Phinney hypothesizes that each component
contributes to self-esteem and that all elements taken together bring about adaptation. These key elements are “self-identification as a group member; attitudes and evaluations relative to one’s group; attitudes about oneself as a group member; extent of ethnic knowledge and commitment; and ethnic behaviors and practices” (p.58).

Ethnicity and the Family

According to McGoldrick (1982), ethnicity is a “major form of group identification and a major determinant of our family patterns and belief systems” (p.3). Triandis (1994) suggests that Hispanics are more collectivist than non-Hispanics. He notes that collectivists value relationships at the forefront with the individual in the background. This results in a greater expectation of harmony in in-group relationships. Latino families are said to emphasize the family as opposed to the individual. Keefe and Padilla (1987) note that family structure is an important aspect of ethnicity, especially among Chicanos. They note that there are many similarities between Mexican American and Anglo American families such as the nuclear family being the basic and most significant family unit; with relatives being visited more frequently than non-kin. But they note that what is not found in Anglo American kinship systems is a “pattern of fictive kinship” (p.129). This Chicano fictive kinship is extended family that includes padrinos (god
parents) who are known as *compadres* (co-parents). *Padrinos* are chosen by parents for young children, as well as by young couples for their marriages. The relationship to the *compadres* is known as *compadrazgo* and is expected to last a lifetime. Religious rituals formalize these relationships such as baptisms, confirmations, and marriages. Researchers have found that fictitious kin fill the same role as real kin in the extended families and are expected to render mutual aid when it is needed (Clark, 1959; Madsen, 1964; Rubel, 1966, cited in Keefe & Padilla). This has important implications for the view of family caregiving. According to Cuellar (1990), "most Hispanics are socialized to believe that the needs or welfare of the family as a whole or other individual family members, particularly the very young or very old, should take precedence over one's own needs, thus children and older adults alike are often shown, that during good times or bad, *la familia* comes first" (Cuellar, p.358). This changing of the individual to fit the situation is a value orientation of a collectivist culture (Triandis, Bontempo, & Villareal, 1988; Triandis, 1994).

This collectivist perspective, thought to be the defining feature of the Latino population, is exemplified in the distinguishing Mexican cultural value of *familism* (Baca Zinn & Wells, 2000). Ramirez and Arce (1981) propose that familism is comprised of four components: 1) demographic profile of the family; 2) structure and incidence of
multigenerational households; 3) normative values on family
unity and solidarity; and 4) behaviors reflecting the
importance of the family for the individual as well as the
emphasis and priority given to the needs of the family as
opposed to personal needs. According to Sabogal, Marin,
Otero-Sabogal, VanOss Marin, & Perez-Stable (1987), familism
consists of three basic dimensions; 1) familial obligations
2) perceived support from family and 3) family as support.
In general, both definitions depict familism as the strong
attachment and identification of individuals to their
nuclear and extended families, with feelings of loyalty,
solidarity, and reciprocity. Consideration of family
structure is basic in appreciating the distinctions found
from one generation of Mexican Americans to another. The
migration/immigration process produces an expected
disruption of social networks (Sabogal, et al.) and not
surprisingly these individuals report smaller local primary
kin groups (Keefe & Padilla, 1987). In contrast, native-
born Mexican Americans (second generation) count more
relatives; report greater interaction and exchange of aid
with more relatives than immigrant, first generation
individuals. It is also significant to note, “this kin
network becomes more and more localized from generation to
generation” (Keefe and Padilla, p.139). Family caregiving
in Mexican American families is rooted in familism. In
addition, interdependence of assimilation, acculturation and
ethnicity is significant in understanding why, when, and how caregiving decisions are made by Mexican Americans. Although immigration causes social network disruption and first generation caregivers may be rare, this researcher expected that immigrant, first-generation and second generation caregivers would be found, therefore this study concerned all generations of Mexican American caregivers. Because the history of the Mexican American family in the United States reflects mixed generations, a qualitative approach was used to document generational status, and ethnicity identification.

Significance to Nursing

The ultimate aim for nursing is to provide care in a manner sensitive to the needs of individuals and their families. As healthcare environments increase in diversity, care must respect the differences and similarities of cultural values, beliefs, and life styles (Leininger, 1997). Development and enhancement of critical thinking skills can assist nurses in understanding how culture influences individual views of health and illness, as well as response to treatment. As society becomes more ethnically diverse, it is of critical importance that nurses recognize the value of providing culturally appropriate care (Ryan, Twidbell, Miller, Brigham, 1996; Amerson, 2001). “The critical issue is the use of research-based knowledge, principles and
concepts... to uphold and build on the ongoing knowledge and practice” of nursing (Leininger, p. 342). This study was
designed to add to the knowledge regarding Mexican American family caregiving.

Statement of Purpose

The purpose of this exploratory study was to 1) develop an intergenerational caregiving model for Mexican Americans focusing on the temporal axis of caregiving; 2) to describe the influence of culture on this model. Specific research questions were:

1. What are the characteristics of the temporal axis for Mexican American Caregivers?
   a. How do Mexican Americans define caregiving in terms of family structure or generational attitudes (historical time)?
   b. What and how do shared understandings with elders and among family members influence who assumes the caregiver role and when (kin time)?
   c. How does entry into the caregiving role affect the entire family (intergenerational development time)?
   d. How does entry into the caregiving role affect the caregiver’s peer relationships (peer time)?
2. To what extent do cultural values guide the caregiver during the trajectory of the caregiving experience?

3. How is the Mexican American caregiving model influenced by acculturation?

Because the grounded theory provides procedural methods that discover concepts and relationships in raw data while organizing them into a theoretical explanation, this methodology was used to answer these questions. It was assumed that Mexican Americans defined caregiving and made decisions related to the executions of said decisions in the context of cultural values, one of which was *familism*.

**Summary**

An abbreviated history of the evolution of the Mexican American in the United States has been given in an effort to better understand how this process has, and continues to have, an effect on all generations of Mexican Americans in their daily lives. Acculturation, assimilation, and ethnic identification are multifaceted dynamic processes that influence the construct of intergenerational family caregiving for Mexican Americans.

The temporal axis within the caregiving paradigm (Kahana et al. 1994), in addition to definitions of historical time, kin time, peer time, and intergenerational
development time (Burton & Sorenson, 1993) provided the framework for this grounded theory study.

Developing and testing of an intergenerational caregiving model from the perspective of individuals in different generations represents a long-range research program. This investigation of Mexican-American caregivers was designed to document and understand how caregiving was defined; who made the decisions; when these decisions were made; and how they were carried out. This knowledge can assist nursing in the delivery of culturally competent nursing care.
CHAPTER TWO
REVIEW OF THE LITERATURE

The review of the literature is presented in four parts. Part one discusses the three concepts of acculturation, assimilation and ethnicity. Part two deals with caregiving in general. Part three presents intergenerational caregiving models found in the literature and part four reviews Mexican-American caregiving literature.

Acculturation, Assimilation, and Ethnicity
In the mid 1930s, the Social Science Research Council (SSRC) appointed three distinguished anthropologists and one sociologist to a subcommittee on acculturation for the purposes of identifying and defining the parameters towards the formal adoption of acculturation as an area of scientific inquiry (Broom, Siegel, Vogt, Watson, & Barrett, 1954). Following this meeting, acculturation research involved studies about the increased contact between individuals in third world nations and those in industrialized Western societies. In North America, the focus was on the acculturation of American Indians to European culture. In the early 1960s, the disciplines of sociology, psychology and psychiatry adopted acculturation as an area of investigational research in the United States
From the perspective of sociology, the group process of assimilation within the context of minority group and race relations was a primary interest of sociology (Gordon, 1978). "Psychologists and psychiatrists conceptualized acculturation as an intra-psychic phenomenon, dealing with changes in the perceptions, attitudes, and cognitions of the individual...focused on the wide range of individual differences in acculturation levels" (Olmedo, p. 28). Acculturation, as a concept, has been applied to mean "change primarily within immigrant or minority ethnic groups whose culture becomes more and more like that of the dominant majority group" (Keefe & Padilla, 1987, p.14).

Keefe and Padilla (1987) present three acculturation models, involving a notion of biculturalism. The first model is a single-continuum model (Figure 2.1) that "assumes the gradual replacement of traditional cultural traits with Anglo American traits" (Keefe & Padilla, p.16). A bicultural person on this continuum would be half way to completing acculturation. The assumption in this model is that a person trades ethnic traits for Anglo traits. Brunner (1956) and Samora and Deane (1956) write of acculturation being determined by a single trait. The single continuum acculturation model provides poor bases for this investigation of the influence of acculturation on care giving of elders as it assumes that persons as they progress from being un-acculturated to being acculturated,
change to some extent in all aspects of life, therefore across all culture traits.

The second model of acculturation is a two-culture matrix (Figure 2.2). The model treats two cultural systems independently as separate axes forming a matrix. Each culture is perceived as a single continuum, and individual acceptance and adherence to the two cultures varies. Individuals who add traits from the new culture to their native traits are considered bicultural, while individuals who do not fully accept either culture are deemed marginal. Poggie (1975) tells a story of a man who is not 100% of either culture and states that this is difficult position to be in, since this marginality results in an individual being “denied meaningful roles” (p.xii) in either culture.
Figure 2.1
Single Continuum Acculturation Model

(Keefe & Padilla, 1987, p.17)

Figure 2.2
Two-Culture Matrix Acculturation Model

(Keefe & Padilla, 1987, p.17)
A third model of acculturation is known as the multidimensional model (Figure 2.3). This model allows for individuals to accept new cultural traits and discard traditional cultural traits on a trait-to-trait basis. Individuals are able to pick and choose which traits they adopt, discard, and/or maintain. In this model, each aspect of culture change must be measured independently (Keefe & Padilla, 1987).

The multidimensional model has been useful, for example, in the study of ethnic political mobilization (Ambrecht & Paghon, 1974) and cultural awareness and loyalty (Padilla, 1980; Keefe & Padilla, 1987). This selective multidimensional model is advantageous in that it allows consideration of new cultural and social patterns that may have been created by migrants and ethnic minorities in the new society. Acculturation, while referring to the acceptance of cultural patterns and traits, does not ensure assimilation. In order for assimilation (the social, economic, and political integration of an immigrant or ethnic minority group member into mainstream society) to occur, the minority group member must have acculturated to some extent and must be
Figure 2.3
Multidimensional Acculturation Model

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
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<tbody>
<tr>
<td>Trait A</td>
<td></td>
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<tr>
<td>Absent</td>
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<td></td>
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<td>Trait B</td>
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<tr>
<td>Trait C</td>
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<tr>
<td>Absent</td>
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</table>

(Keefe & Padilla, 1987, p.17)
accepted by the dominant group. The distinct social,
etconomic, and political aspects of assimilation are
important because social assimilation involves the
integration of ethnic minorities into primary and secondary
relations with members of the dominant group. It is
essential in this study of family caregivers to especially
understand primary relations, which include intimate and
informal interaction as family members (through marriage)
and friends, and in private leisure activities in the home
and in conjunction with family and friends. To a lesser
degree are secondary relations (which occur first) which
include the less intimate and more formal interactions which
occur at work, in school, at social agencies, in the
political arena, and in places of mass entertainment (Keefe
& Padilla, 1987).

The two-culture matrix and multidimensional
acculturation models provide poor bases for the
investigation of the influence of acculturation on care
giving of elders as they are unable to deal with variation
in the process of culture change. This has caused
researchers to increasingly turn to the study of ethnic
identification. "Here the particular assemblage of cultural
traits becomes less important than the attitudes of members
toward the people and culture of the in-group versus the
out-group as well as members' self-identification" (Keefe &
Padilla, 1987, p. 41). The ethnic identity dimension is of
special interest to this investigation of Mexican American caregivers.

Ethnic identity is composed of self-identification, a sense of belonging; attitudes about one’s group membership, and ethnic involvement as in social participation, cultural practices and attitudes. According to Phinney, (1990) ethnic identity development undergoes four stages. These stages are:

1. Diffuse: Little or no exploration of one’s ethnicity and no clear understanding of the issues.
2. Foreclosed: Little or no exploration of ethnicity, but apparent clarity about one’s own ethnicity. Feelings about one’s ethnicity may be either positive or negative, depending on one’s socialization experiences.
3. Moratorium: Evidence of exploration, accompanied by some confusion about the meaning of one’s own ethnicity.
4. Achieved: Evidence of exploration, accompanied by a clear, secure understanding and acceptance of one’s own ethnicity (p.38).

Figure 2.4 depicts how ethnic identity is seen as a continuum between two points, and individuals may be located at some point from low to high.
Figure 2.4

Ethnic Identity as a Continuum

*High, strong, secure, or achieved ethnic identity:*
Self-identification as group member
Involvement in ethnic behaviors and practices
Positive evaluation of the group
Preference for own group; happy with one’s membership
Interest in knowledge about the group
Commitment, sense of belong to the group

*Low, weak, or diffuse ethnic identity:*
Self-identification as group member
Little involvement in ethnic behavior
Negative evaluation of group
Preference for majority group; unhappy with one’s membership
Little interest in or knowledge about group
Little commitment or sense of belonging to group

Phinney, 1995, p.59
Keefe and Padilla (1997) contend that “at least two processes of cultural orientation and change exist among Mexican Americans” (p.46). These processes are cultural awareness and ethnic loyalty. Cultural awareness refers to the individual’s knowledge of cultural traits such as language, history, and culture heroes. Ethnic loyalty is the individual’s “preference for one cultural orientation and ethnic group rather than another” (p.46). “Within every culture there are preferred whos whats whens and wheres which are held up as models to be emulated”, while the family cultural pattern that we learn, defines the content of identities and interactions (McCall & Simmons 1978, p.24). Keefe and Padilla’s typology of Mexican American ethnic orientation provides the framework to describe caregivers’ identities and interactions of the caregiving role in the context of ethnicity in this study. These five types are described in terms of individuals’ attitudes toward American culture and people, and their perception of discrimination against people of Mexican descent in the United States. Table 2.1 outlines these five types.
Table 2.1

Typology of Mexican American Ethnic Orientation

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
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<tbody>
<tr>
<td>Type I</td>
<td>La Raza</td>
</tr>
<tr>
<td>Type II</td>
<td>Changing Ethnics</td>
</tr>
<tr>
<td>Type III</td>
<td>Cultural Blends</td>
</tr>
<tr>
<td>Type IV</td>
<td>Emerging Americans</td>
</tr>
<tr>
<td>Type V</td>
<td>New Americans</td>
</tr>
</tbody>
</table>

Keefe & Padilla, 1987
Keefe and Padilla (1987), describe La Raza, type I, as individuals who identify as Mexicans and with Mexican culture. These individuals are likely to be first generation who arrived in the United States as adults. They tend to be lower class, less educated, less socio-economically mobile; and they are likely to live in barrios. They appear to have no doubt when self identifying as "Mexicano". Their homes may have religious statues and pictures of Mexican saints. Their knowledge of Mexican traditions and customs is extensive, especially Mexican national holidays with relatively little knowledge about United States holidays. They may see dissimilarities with themselves in relationships between neighbors, with people living in the United States being viewed as more isolated and unfriendly than those of Mexican heritage.

The Changing Ethnics, type II, individuals are described to have similar characteristics to type I, likely be lower class, less educated, and barrio residents. They tend to be first generation, having come to the United States as young adults. They identify as "Mexican" and don’t see how a Mexican can become an American, once a Mexican, always a Mexican. They are strongly attached to the Mexican heritage, and become disturbed when others criticize it in any way. They have adopted the celebration of holidays such as Halloween and Thanksgiving, and do not celebrate some Mexican traditions such as quinceañera
(Mexican coming out party) because these are not American. They prefer speaking Spanish to English, and are more comfortable living in neighborhoods of residents of Mexican decent. There may be positive feelings about Americans, but they don’t necessarily want to become American.

The Cultural Blends, type III, are likely to be second generation, better educated, and of higher socioeconomic status than type II. These individuals feel they are both Mexican and American. They participate in Mexican customs, but acknowledge their limitations of Mexican cultural awareness. They selectively participate in both cultural orientations, but they are not equally adept in both cultures. They interact extensively with Anglos on a daily basis. Even though they are proud of their Mexican heritage, they do not identify as Mexican. They most likely will say they are Mexican American or Chicano, while holding “different opinions regarding the term Chicano” (Keefe & Padilla, 1987, p.95). To one individual the Chicano self identification can signify “both an ethnic and political designation” (p.95) but to another this might be a label of being a “radical” (p.96).

Emerging Americans, type IV, also tend to be second generation, with individuals having experienced more socioeconomic mobility and having relatively higher levels of education and occupational status than type III. They are likely to live outside the barrio. Even though their
knowledge of Mexican culture is variable, they are clearly familiar with American values and customs. They have a preference to be identified as Americans of Mexican decent. Despite internalization of American values, these individuals have not, in their own view, achieved complete status as Americans.

New Americans, constitute type V and are likely to be third or later generation; to live outside the barrio; and to have an urban background. These individuals can be inconsistent in their self identification. They may at times self identify as American and at other times, depending on the environment, may admit to have Mexican ancestry if asked. They can be of mixed heritage, resulting in individuals considering themselves American whose heritage happens to be partly Mexican. They are somewhat more educated but not necessarily of higher occupational status, higher income, or greater socioeconomic mobility than type IV. There is no Mexican and/or Mexican American cultural influence in their life in perceptible ways. They do not celebrate Mexican holidays or know their significance. They acknowledge their Mexican heritage, but do not consciously maintain it.

Summary

Acculturation studies have emphasized measures such as behavior, values, social relationships, language use, and
food preferences (Szapocznik, Scopetta, & Kurtines, 1978; Cuellar, Harris, & Jasso, 1980; Olmedo, 1980) or have investigated dimensions of cultural awareness versus cultural loyalty (Padilla, 1980). Studies have also focused on beliefs and attitudes versus behavior (Sabogal, et. al. 1987), and the relationship of acculturation to family functioning (Rueschenberg & Buriel, 1989). It was the relationship of ethnic identification to family structure and functioning that was of special interest to this researcher. Acculturation and ethnic identity for this study was assessed by having subjects share their caregiving experiences, how this caregiving related to family (Ramirez, 1983), and what ethnic differences they saw if any, in an effort to capture the uniqueness of the individual and the unique nature of life circumstances.

Caregiving

The term caring as applied to the interactions between families and cared for persons is very much a product of the 1980s (Arber & Ginn, 1990). According to George, in 1994, the academic literature on caregiving had grown significantly in both volume and sophistication. Concerns that had been raised in 1986 had been addressed. By 1994, 1) studies “reflected that caregivers [suffered] decrements in some dimensions of well being relative to their non-caregiving peers”; 2) “multiple dimensions of caregiving
consequences” were “typically examined separately”; and 3) “several conceptually and psychometrically excellent measures of caregiver burden and related concepts” had been developed (p.6). She concluded that “despite a decade of fertile effort and increased sophistication of the research base, there was still much to learn about the conceptual and operational underpinnings of caregiver research” (George, p. 7).

Given and Given (1991) reviewed family caregiving literature from the previous ten years. They found that researchers approached this topic from the perspective that “caring for the elderly is difficult, time-consuming, and emotionally and physically burdensome” (p.78). They noted that the literature addressed the following seven areas:

1. Characteristics of the caregiver
2. Characteristics of the care recipient
3. The processes of caring for elderly in the home
4. Caregivers’ reactions to the caregiving processes
5. Impact of caregiving on caregiver physical health
6. Impact of caregiving on employment and other roles
7. Formal and informal support and resources.

Nolan, Grant, and Keady (1996) summarized the family caregiving literature with the following themes.

1. Predominantly focused on the burdens or difficulties of caring.
2. A concentration on the tasks or physical aspects of caring, especially in the way that caring has been defined.

3. Methodologically most research has adopted a quantitative approach using cross-sectional designs.

4. The majority of the studies have focused on the caregiver.

5. The satisfactions or reinforcements have been relatively neglected.

6. The way in which caregivers cope with and/or manage their situations has not been fully addressed.

7. The geographical areas of study have been predominantly the United States and United Kingdom, lacking different theoretical approaches and cultural traditions.

Farran (2001) reviewed five types of intervention studies during the 1980s and 1990s from a psychosocial focus. Table 2.2 outlines the types and contributions made by caregiving intervention research in the 1980s and 1990s.

The caregiving literature uses multiple terms to describe the effects of caregiving. This leads to difficulty and sometimes confusion in attempting to synthesize the literature. Investigators have documented negative and positive effects and have conceptualized these in a variety of ways. A literature search was conducted on
MEDLINE and CINAHL computerized databases. Keywords for search were caregiver, caregiving, family caregiving, caregiver burden, caregiver satisfaction, and caregiver appraisal. The search was done from 1966 to 1986;
Table 2.2
Contributions of Caregiving Intervention Research

<table>
<thead>
<tr>
<th>Years</th>
<th>Type of Intervention Studies</th>
<th>Contributions Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980s</td>
<td>Psychosocial &amp; support groups</td>
<td>Caregiver and care-receiver conceptual issues identified</td>
</tr>
<tr>
<td></td>
<td>Skills Training</td>
<td>Basic measurement issues addressed</td>
</tr>
<tr>
<td></td>
<td>Psychotherapy</td>
<td>Basic content for psychosocial group interventions specified</td>
</tr>
<tr>
<td></td>
<td>Counseling</td>
<td>Descriptive work guided the next phase of skill building intervention research</td>
</tr>
<tr>
<td></td>
<td>Respite Care</td>
<td></td>
</tr>
<tr>
<td>1990s</td>
<td>Expanded in-home services</td>
<td>Research design &amp; sampling issues identified</td>
</tr>
<tr>
<td></td>
<td>PREP advice line (PAL)</td>
<td>Intervention &amp; measurement issues addressed</td>
</tr>
<tr>
<td></td>
<td>Keep in touch (KIT)</td>
<td>Descriptive research of positive aspects of caregiving conducted</td>
</tr>
<tr>
<td></td>
<td>Completion</td>
<td>Descriptive research of multicultural issues conducted</td>
</tr>
</tbody>
</table>

(p. 38-39)
from 1987 to 1996; and from 1997 to 2003. Results of this search demonstrated that the vast majority of articles appeared between 1987 and 1996. During this period, the literature base increased less than 50%, with a 50% increase from 1997 to the present (Appendix A). Studies reviewed were found to address three aspects of caregiving. First, there were studies of negative concepts such as burden, hassles, strain, and stress. Second, there were studies of positive concepts such as caregiver esteem, uplifts of caregiving, satisfaction, and finding meaning, in the caregiving experience. Third studies focused on caregivers describing the process and rendering an appraisal of the experience (non-aligned).

In addressing this literature, the intention is not to provide a review of the entire field, but instead to refer to some articles as exemplars. The concepts of negative, positive, and non-aligned were added to the who (spatial), when (temporal), and what (transactional) axis of Kahana and colleagues (1994) caregiving paradigm to organize this literature review (Appendix B). The investigational intent of the studies determined the classification of negative, positive or non-aligned. A total of 61 studies were reviewed. Thirty-four were found to focus on the negative aspects of caregiving, eight dealt with positive aspects, and 18 addressed non-aligned descriptions of caregiving.
Negative Aspects of Caregiving

Numerous and varied studies focus on negative aspects of caregiving. Some researchers have been concerned with caregiving outcomes such as poor morale, poor psychological well-being, negative affect, and depression and their potential effect on other outcomes such as institutional placement of the impaired elder (Poulshock & Deimling, 1984; Deimling & Poulshock, 1985; George & Gwyther, 1986). Other inquiries have been in areas of personal and social resources available to caregivers as well as family conflict, socio-emotional and instrumental support (Turner, Pearlin, & Mullan, 1998; Gaugler, Zarit, & Pearlin, 1999; Gaugler, Pearlin, Leitsch & Davey, 2001). Depression was identified as being one of the focal outcomes of caregiver strain (Rosenthal, Sulman, & Marshall, 1993; Kinney, Stephens, Franks, & Norris, 1995; Deimling, Smerglia, & Schaefer, 2001) suggesting the need for respite and eventual institutional placement (Deimling & Poulshock, 1985; Deimling, 1991; Zarit & Whitlatch, 1992). Caregiving strain, caregiving environments for the functionally and cognitively impaired (Bass, McClendon, Deimling, & Mukherjee, 1994; Grant, Adler, Patterson, Dimsdale, Zielger, & Irwin, 2002) as well as informal support systems for AIDS patients (Pearlin, Semple, & Turner, 1988; Pearlin, Aneshensel, & LeBlanc, 1997) have also been studied.
According to Montgomery, Gonyea, and Hooyman (1985), a "major contribution of the caregiving literature is the conceptual and operational development of the concept of burden" (p. 20). They noted that the concept of burden had been modified in order to recognize the importance of separating events, happenings, and activities (objective measures of burden) from feelings, attitudes, and emotions (subjective measures of burden)" (p. 20). Montgomery and Williams (2001) group these secondary strains under four general headings: "infringement on time and life style, impacts on the caregiver—care receiver relationship, mental health, and physical health" (p. S24). Montgomery, Gonyea, and Hooyman (1985) separate burden into subjective burden which is related to characteristics of the caregiver such as feelings, attitudes, and emotions from objective burden that is related to the type of caregiving tasks performed such as events, happenings, and activities. This burden perspective is seen in studies that focus on demands and hardships associated with type of care provided; the need for respite care; activities of daily living, obligation to the elder, and division of household tasks (Kosloski, McGlinn Datwyler, & Montgomery, 1994; Kosloski, Montgomery, & Karner, 1999; Braithwaite, 2000; Kosloski, Montgomery, & Youngbauer, 2001). Pearlin, Mullan, Semple, and Skaff (1990) asserted that where caring is the affective component of an individual’s commitment to the welfare of another, with
caregiving serving as the behavioral expression of this commitment, the emergence of a serious and prolonged impairment which leads to dependency on others restructures the relationship. This is a transformation from an ordinary exchange of assistance to an extraordinary burden. Studies of tangible, concrete, and therefore measurable aspects of care have been organized under the umbrella of caregiver burden, while studies that describe the subjective appraisal of strain have been grouped under caregiver stress (Pilisuk & Parks 1988; Parks & Pilisuk, 1991).

Pearlin (1989) presents a stress and coping paradigm that differentiates between primary and secondary stressors, both of which culminate in stress outcomes. A primary stressor is one related to an identifiable event in an individual’s life, such as the untimely death of a loved one. Secondary stressors occur as a consequence of primary stressors, for example those resulting from care of impaired relatives. Pearlin’s (1989) critical overview of concepts and practices in stress research enhances the conceptualized stress model (Pearlin et al., 1990, p. 586). This framework identifies four domains that make up the stress process: the background and context, the stressors, the mediators, and the outcomes or manifestations of stress. The aim of their model is not only to identify conditions that might be associated with stress, but also to discover how these conditions arise and how they come to be related to each
other. The authors believe that conceptualizing caregiving as a “mix of circumstances, experiences, responses, and resources that vary among caregivers as well as in their impact on caregivers’ health and behavior” is useful (Pearlin et al., p. 591).

In addition to the previously discussed research efforts, Pearlin et al.’s (1990) stress model has also served to guide the research in what Pearlin and colleagues identified as secondary strains. Of these thirty-four negative concept focused studies, all but two (94%) dealt with the transactional axis, the processes involved in caregiving (the what), of the caregiving paradigm. One addressed the spatial axis, individuals performing the care (the who), and one dealt with both the spatial (the who) and transactional (the what) axis.

Positive Aspects of Caregiving

Studies of the positive aspects of caregiving focused on measuring the well being of caregivers caring for mildly cognitively impaired individuals; as well as understanding the family environment and the impact of integrated social networks (Gilhooly, 1984; Ward, Sherman, & LaGory, 1984; Smerglia, & Deimling, 1997). Hasselkus and Ray (1988) focused on informal learning in the caregiving situation in efforts to reveal meaning in the sense of self, sense of managing, sense of future, sense of fear/risk, and sense of
change in role/relationship between caregiver and care receiver. Studies have also found that positive appraisals of the caregiving situation as well as respite care can function to protect individuals from the negative effect of caregiving responsibilities (Kinney, Stephens, Franks, & Norris, 1995; Braithwaite, 1998). Other studies have focused on methods of assessing caregivers’ feelings and how they find ultimate meaning; of developing a theory of enrichment that explains how some families use pleasurable, meaningful experiences in caring for their elders (Farran, Miller, Kaufman, Donner, & Fogg, 1999; Cartwright, Archbold, Stewart, & Limandri, 1994). All studies reviewed under the positive concept were focused at the transactional axis (the what) of the caregiving paradigm.

Non-aligned Descriptions of Caregiving

Studies designed with an investigational intent of appraising the caregiving situation comprise a third category identified as non-aligned. Findings from this type can be positive, negative, non-aligned, or can also be a combination of any or all three expressions of the caregiving situation. Studies have intended to document subjective factors that influence the size, scope, composition and quality of informal social support systems for primary elder caregivers (Johnson & Catalano, 1983; Penrod, Kane, Kane & Finch, 1995). Investigation of belief
systems, frustrations, gratifications, and well being of dementia caregivers has also been conducted (Kopito-Motenko, 1989; Albert, 1992). Other studies have looked at the reciprocal process of becoming strangers in care of the demented as well as how family relationships affect caregivers’ responses to their caregiver situation (Wuest, Ericson, & Stern, 1994; Barnes, Given, & Given, 1992). The impact of caregiving on relationships in general, as well as specific mother-daughter relationships has been studied (Walker, Shin, & Bird, 1990; Albert, 1990; Walker & Allen, 1991). Still others have turned to the meaning of caregiving and the discovery of how families adapt to caregiving changes and functions in light of inner and outer demands, the utilization of respite services, and the impact of respite care on informal caregivers (Davis, 1980; Sterritt, & Pokorny, 1993; Kosloski & Montgomery, 1994; Braithwaite, 1996; Beach, Schulz & Yee, 2000; Kosloski, Montgomery, & Youngbauer, 2001). Some of the latest studies are showing the need for information related to specific types of caregivers such as those caring for new survivors of stroke or caregiving among White, Black, and Hispanic caregivers (Navaie-Waliser, Feldman, Gould, Levine, Kuerbis, & Donelan, 2001; Brereton & Nolan, 2002).

The household or family milieu is the context where immediate care is provided. It could be reasoned that this context is principally determined by three elements: a) the
level and type of impairment of the elder, b) the relationship between the caregiver and the elder, and c) the living arrangement of the elder. "Decisions about what type of care is provided, who provides the care, and the manner in which it is provided are made within the parameters of these three elements" (Montgomery & Williams, 2001, p. S27). Research studies reviewed under the non-aligned concept were distributed among all three axis, with twelve focused in the transactional (the what) axis, one in the spatial (the who) axis, two in both the spatial (the who) and transactional (the what) axis, and two in the spatial (the who) and the temporal (the when) axis. The two reflecting temporal properties were 1) an exploratory study by Davis (1980) with foci that were the initial weighing process in the decision to keep the disabled care receiver at home, the range of responsibility in caregiving, the interactional system which served as the social unit, and the social context and adaptation the family made to the situation; and 2) a grounded theory study by Wuest, Ericson, and Stern (1994) who explored the reciprocal process of becoming strangers in which caregivers and care receivers with Alzheimer’s disease interacted on a continuum from intimacy to alienation.

Because this study was focused on the temporal axis, work done by Wilson (1989), Bowers (1987), and Nolan and colleagues (1995, 1996, & 1997) which focus on the temporal
and longitudinal aspects of caregiving, was of special interest. These studies are reviewed in greater depth.

Wilson (1989a; 1989b) describes eight stages that unfold in the course of Alzheimer’s disease. Stage one is noticing only recognized retrospectively as changes are viewed “as having come about slowly”. Stage two is discounting and normalizing where changes that are noticed are discounted and attributed to “old age”. Stage three is suspecting. This stage occurs after a particular event that causes family members to begin to speculate about what is going on. Stage four, searching for explanations, involves seeking confirmation of a diagnosis and is a stage that is undertaken reluctantly. Stage five, recasting, is when, having established a diagnosis, families find themselves re-appraising retrospectively various experiences with their demented relative. Stage six is taking it on. This is where families decide to take on home care, an action that is primarily motivated by a keen sense of moral duty. Stage seven is going through it. This stage includes the process of caring for the relative and includes the unending list of problems that must be solved on a trial-and-error basis. The eighth stage, turning it over, occurs when caregivers consciously and reluctantly let go of control of the direct care of their relative. They may entrust this care to an outsider in terms of institutional care. Wilson’s stage model provides a beginning to understanding the temporal
experience of how families progress through the stages of providing care for family members with dementia.

Bowers (1987) proposes a typology of family caregiving with five conceptually distinct but overlapping categories. The first is anticipatory caregiving, which includes decisions that are based on anticipated, possible needs of a parent. The second is preventive caregiving and this category includes caregiving activities performed with the purpose of preventing illness, injury, complications, and physical and mental deterioration. The third category is that of supervisory caregiving which involves active and direct activities such as arranging for, checking up, making sure, setting up, and checking out. The fourth is instrumental caregiving, which involves doing for, assisting, providing and giving, in other words this is the hands-on caregiving. The fifth and last category is protective. The purpose of activity in this category is to protect the parent from the consequences of that which was not or could not be prevented.

Nolan, Keady, and Grant (1995) extended Bower’s model by three categories. They redefined the anticipatory category to involve activities about not only “in case of”, but also about “what would I do if...?” (p.264). Nolan and colleagues (1995; 1996) present the addition of preservative and reconstructive care to the category of protective, and present these together due to the three being “considered to
have a temporal relationship” (Nolan, Keady, Grant & Gordon, 1995, p.262). Protective actions are those intended to shield the cared for person from the obvious, such as a diagnosis, while preservative actions are aimed at maintaining self-esteem. The reconstructive category becomes necessary since preservative and protective care is possible only up to a certain point. Reconstructive care builds on the past but also seeks to actively develop new and valued roles. Additionally they propose the last category to be that of reciprocal care. Both the Bowers and Nolan et al. typologies define caring by meaning or purpose and not the nature of the task involved.

These three models move away from the predominantly instrumental perspective to a temporal perspective of caregiving. All three describe the unfolding family caregiving experience, but only Wilson’s model is sequential. Table 2.3 illustrates the similarities and differences between caregiving experiences in the three models, Wilson’s model of eight stages, opposed Bowers and Nolan et al. typologies of five and eight categories.

The limitation of the Bowers and Wilson models is that they are focused on the care of persons with dementia. Expansion of Bowers model by Nolan and colleagues has focused on the need for interventions that are category specific, tailored towards the caregiver’s need during a
particular point in the caregiving trajectory (Nolan, Keady & Grant, 1995; Nolan, Grant, & Keady, 1996; Dellasega & Nolan, 1997). This study explored the temporal influences that defined who and when the individual accepted the role of caregiver in this sample of Mexican American caregivers.
Table 2.3
Similarities and Differences of Three Models

<table>
<thead>
<tr>
<th>Wilson</th>
<th>Bowers</th>
<th>Nolan et al.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noticing</td>
<td>Anticipatory</td>
<td>Anticipatory</td>
</tr>
<tr>
<td>Discounting and</td>
<td>Preventive</td>
<td>Preventive</td>
</tr>
<tr>
<td>Normalizing</td>
<td>Supervisory</td>
<td>Supervisory</td>
</tr>
<tr>
<td>Suspecting</td>
<td>Instrumental</td>
<td>Instrumental</td>
</tr>
<tr>
<td>Searching for</td>
<td>Protective</td>
<td>Protective</td>
</tr>
<tr>
<td>explanations</td>
<td></td>
<td>Preservative</td>
</tr>
<tr>
<td>Recasting</td>
<td></td>
<td>Re constructive</td>
</tr>
<tr>
<td>Taking it on</td>
<td></td>
<td>Reciprocal</td>
</tr>
<tr>
<td>Going Through It</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turning It Over</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mexican American Caregiving Literature

Although Mexican Americans, as part of a greater Hispanic population, constitute a fast growing segment of the elderly population, relatively little has been documented about the Mexican American approach to care of the elderly. The literature presents critical issues that must be considered in cross-cultural research such as the need for a clearly defined population, the development of a comparative descriptive framework that assures functional equivalence, and the development of appropriate instrumentation (Phillips, Luna, Russell, Baca, Lim, Cromwell, & Torres de Ardon, 1996). Phillips and colleagues formed a research team that systematically addressed all these issues. They explored similarities between the Anglo and the Mexican American quality of family caregiving reporting that even though basic human rights do not vary across cultures, there is a variance in behavioral indicators of these standards (Cromwell, Russell, Lim, Luna, Torres de Ardon, & Phillips, 1996). The same team developed a cross-cultural equivalent definition of burden and found that the “extent to which burden has an adverse effect on the family caregiver depends partly on cultural factors and perceptions driven by the social environment” (Lim, Luna, Cromwell, Phillips, Russell, & Torres de Ardon, 1996, p. 264). The concept of familism was also addressed, finding
that the “value of familism and the manifestations of differing worldviews may differentially affect the care provided to loved ones” (Luna, Torres de Ardon, Lim, Cromwell, Phillips, & Russell, p. 279). Robert, Rosendiz, and Vargas (1999) found that in discussing attitudes and feelings of caregiver burden, participants were “consciously influenced by notions and norms of familism” (p.159).

Another study focused on the relationship of elder to caregiver, assistance given by the caregiver, and caregiving roles, reporting that Mexican American caregivers “more positively evaluated their role, had less desire for termination of the relationship, and adult children had greater role satisfaction than non-Hispanic” caregivers (Phillips, Torres de Ardon, Komnenich, Killeen, & Rusinak, 2000, p. 309). The most recent study found in the literature attempts to explore the dynamics of caregiving in Mexican American families with a focus on the differences between highly acculturated and less acculturated caregivers, finding that Spanish-speaking caregivers have difficulty responding to questions regarding satisfaction with care provided (Jolicoeur & Madden, 2002).

Summary

In summary, the proliferation of literature within the caregiving field of study, calls for taking stock “of where we have been [in order] to move in directions that will lead
to the discovery of new meanings and uncover fruitful understandings” (Gubrium 1995, p.276). He proposes that this area of research return to its first principles and ask “What is this thing some call caregiving? How does it relate to the way everyday life is practiced in relation to it? And what do our answers to these questions suggest about the possibility that the effort can be assessed and evaluated as a whole?”(Gubrium, p. 268-269) It was the intent of this investigation to document intergenerational Mexican-American caregiving, while attempting to understand the characteristics of the informal temporal axis for Mexican American caregivers and to explore the extent of the influence of cultural values on the caregiving experience.
Chapter Three describes the method used for this exploratory study in four sections. The first section is a brief discussion of symbolic interaction theory as the philosophical foundation of grounded theory methodology. The second section, entitled grounded theory, includes the history, definition and usefulness of grounded theory, as well as an overview of the grounded theory process, theoretical sensitivity, and the role of the researcher. The third section entitled methods includes sample selection, description of sample, and recruitment. Also found in this section are procedures/operations which includes data collection, interviews, data analysis, analytical procedures for acculturation and ethnicity, establishing trustworthiness, member checks, and peer debriefing. The fourth section describes key markers for the measurement of acculturation and ethnic identity.

Symbolic Interactionism

According to Benzies and Allen (2001), H. Blumer is credited with coining the term “symbolic interactionism” in 1937, when he interpreted the work of George Herbert Mead (1863-1931) a professor of philosophy at the University of Chicago. During this era, symbolic interactionism was
presented as an alternative to the uncritical behaviorism and extreme positivism of the structural-functional approaches, both common in sociology. McCall and Simmons’ (1978) theory of symbolic interactionism suggests that social acts account for the dynamics of arriving at a consensus on the identities and meanings of individuals around us. It proposes that a working agreement exists when the “cognitive processes of one person...are not in gross conflict with the expressive processes of the other person” (p.139). Symbolic interactionism states that although the world exists separately and apart from the individual, it is the individual’s perceptions and interpretations that structure his or her world and influence his or her behaviors. These perceptions and behaviors are distinctive processes that constantly change depending on how the individual interprets the world (Benzies & Allen, 2001). McCall and Simmons (1978) outline the propositions that underlie symbolic interaction. They are as follows:

1. Humans are planning animals. We are thinkers, planners, and schemers. We continuously construct plans of action out of bits and pieces left around by culture. This planning is carried out on all levels, not always verbally, but always conceptually.

2. Things take on meaning in relation to plans. Meaning can be taken as implications for
actions, therefore answering the question of what to do in a given situation. Humans see choice points, therefore always requiring contemplation of alternatives.

3. We act towards things in terms of their meaning for our plan of action. The execution of our plan depends on the meaning we have ascribed to the plan.

4. Therefore, we must identify every “thing” we encounter and discover its meaning. We are always identifying, categorizing, and naming things, while interpreting, construing, and reconstructing them to determine their meanings for plans of action.

5. For social plans of action, meanings must be consensual. If a plan of action involves more than one person, and the plan is not consensual, unless the meaning is resolved by collective effort. And even though the meaning may not be identical in the minds of all concerned, there must be mutual agreement as to the course of action.

6. The basic “thing” to be identified in any situation is the person. For each individual, the key question that needs to be answered is: Who am I in this situation?
What implications do I have for the plans of action, both active and latent, of myself and of the others? The answers constitute the character of the person.

Symbolic interaction is an attempt to "account for the dynamics of the process of arriving at a social consensus on the identities and meanings" of all concerned (McCall & Simmons, p.60). The symbolic interactionist perspective is a philosophical fit for this study that proposes to understand how Mexican American caregivers view their worlds, what they believe to be important, how they engage in the caregiving role given changes in their family structure as well as generational attitudes and how decisions are made about when to enter the caregiving role.

Grounded Theory

Historical Overview of Grounded Theory

The basic assumptions of symbolic interactionism developed into what is known as the Chicago and Iowa schools of thought (Benzies & Allen, 2001). Anselm Strauss and Barney Glaser, both sociologists, developed grounded theory, rooted in symbolic interactionism, in the 1960s. Strauss came from the University of Chicago, which had a long history and strong tradition in qualitative research and was influenced by interactionist and pragmatist writings. Glaser came from a very different tradition. He had received his
training from Columbia University and was influenced by quantitative methods. “While doing qualitative analysis, he saw the need for a well thought out, explicitly formulated, and systematic set of procedures for both coding and testing hypotheses generated during the research process” (Strauss & Corbin, 1990, p.25).

Definition and Usefulness of Grounded Theory

Qualitative research methods, including grounded theory, are useful when little research is found in the area of interest. Qualitative methods are “non-mathematical processes of interpretation, carried out for the purpose of discovering concepts and relationships in raw data and then organizing them into a theoretical explanatory scheme”.... “Research that attempts to understand the meaning or nature of experiences of persons with problems such as chronic illness, addiction, divorce, and the act of “coming out” lends itself to getting out into the field and finding out what people are doing and thinking” (Strauss & Corbin, 1998, p.11).

In this case, little is known regarding intergenerational Mexican American caregiving.

Grounded theory methodology incorporates a system of analytic steps for generating theory. The resulting grounded
theory is inductively discovered, developed, and provisionally verified through systematic collection and analysis of data. The method involves a repetitive process; the researcher must return constantly to data sources, check aspects of the emerging interpretations and continue to gather new data where appropriate. Two basic analytic procedures to the coding process pertain to first, the asking of effective questions about data. There are multiple levels of questions, “abstract and theoretical, substantive and mundane” (Strauss & Corbin, 1998, p.74). Good questions more often depend on the ability of the investigator to be “prompted by relevant knowledge, a sense of something is missing, and sensitivity to what the data really are saying” (Strauss & Corbin, 1998, p. 75); questions which “help to give the concepts their precision and specificity”(Strauss & Corbin, 1990, p. 62-63). The second basic procedure is that of making comparisons. Not only comparison of incident to incident in order to classify them, but also to make use of what is known as theoretical comparisons that stimulate thinking about properties and dimensions that provide direction to theoretical sampling (Strauss & Corbin, 1998). Grounded theory methodology involves “the constant comparative method of analysis” (Glaser & Strauss, 1967, p. 101).
Grounded Theory Process

The grounded theory method, as with most forms of qualitative analysis, has very few concrete ways of “how to do it”, but five key components are involved. These are 1) flexibility with open ended questions, 2) theoretical sensitivity, 3) theoretical sampling, 4) analysis of data, and 5) memos and diagrams.

First the research question needs to be flexible and open to exploring a phenomenon in depth. Flexibility and open-endedness allows the theory to develop.

Second, grounded theory method requires theoretical sensitivity, which refers to a personal quality of the researcher. It “refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t... in conceptual rather than concrete terms” (Strauss & Corbin, 1990, p.42). In other words, the researcher can come to the situation with varying degrees of sensitivity due to professional and personal experience. Theoretical sensitivity is the ability to recognize what is important in data and to give it meaning. Theoretical sensitivity allows the researcher to see the situation and the data in new ways in order to explore the potential for developing theory. The analyst allows the literature to serve as a means to discover relevant categories,
relationships among them; to create new categories in new ways; also to explain the phenomenon as it evolves during the research itself. In quantitative studies, the literature delineates important variables for study, but in grounded theory the literature is used to discover relevant categories and relationships among them; to create new categories in new ways and also to explain the phenomenon as it evolves during the research itself. Therefore, the literature review is an on-going process.

Because it is not easy to make creative use of one’s knowledge and experiences, Strauss and Corbin (1990) offer the following suggestions.

1. Periodically stepping back and asking: What is going on here? Does what I think I see fit the reality of data?

2. Striving to maintain an attitude of skepticism. All explanations, categories, hypotheses, and questions about the data, made directly or indirectly from the comparisons, the literature, or from experience, should be regarded as provisional.

3. Following research procedures. The data collection and analytic procedures are designed to give rigor to a study (p.44-46).

The third component of the grounded theory method is theoretical sampling, a process of data collection for generating theory. In this process the analyst collects, codes, and analyzes data, deciding what data to collect next and where to find them, towards developing the theory as it emerges. The data collection process is controlled by the emerging theory. The primary decisions for theoretical collection of data are based only on the researcher’s general perspective, as well as on a general subject or problem area (Glaser & Strauss, 1967). The general procedure calls for eliciting codes from raw data from the start of data collection, continuing through constant comparative analysis as data increase. The codes direct further data collection, and in turn are further theoretically developed with respect to their various properties and their connections with other codes until saturated. Theoretical sampling on any code ceases when it is saturated, elaborated and integrated into the emerging theory. “This process produces cumulatively intense theoretical sensitivity into one’s data as the integrative matrix of the emerging theory grows denser” (Glaser, 1978, p.36).

Grounded theory method’s fourth component is the analysis of data, which is the heart of the process. Conceptualizing data is the first step in analysis. This process is known as coding and represents the operations by
which data are broken down, conceptualized, and put back together in new ways. “It is the central process by which theories are built from data” through three kinds of coding (Strauss & Corbin, 1990, p.57).

Open Coding. There are several different ways of approaching the process of open coding. There is the line-by-line process, which involves close examination, phrase-by-phrase, and even single word by single word. The second method is coding by sentence or paragraph. Here the researcher searches for the major idea brought out in the sentence or paragraph. The third method is to take an entire document, observation, or interview and ask: “What seems to be going on here? What makes this document the same or different from the previous one” coded (Strauss & Corbin, 1990, p.72-73)? Open coding is used to label phenomena conceptually, discover categories, and develop categories in terms of their properties and dimensions. Each unit of analysis is defined and then compared to every other unit of analysis, so that similar phenomena are given the same name or code.

Axial coding puts the data (from open coding) back together in new relational ways by making connections between a category and its subcategories. Axial coding is distinct from open coding; but the researcher engaged in analysis alternates between the two modes constantly. In axial coding subcategories are related to their categories
through what Strauss and Corbin (1990) call the paradigm model. This model links subcategories to a category in a set of relationships and helps the researcher think systematically about data and to relate them in very complex ways. The model appears as follows:

\[(A) \text{ CAUSAL CONDITIONS } \rightarrow (B) \text{ PHENOMENON } \rightarrow \]
\[(C) \text{ CONTEXT} \rightarrow (D) \text{ INTERVENING CONDITIONS } \rightarrow \]
\[(E) \text{ ACTION/INTERACTION STRATEGIES } \rightarrow \]
\[(F) \text{ CONSEQUENCES (p.99).}\]

Selective coding is the “process of selecting the core category systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development” (Strauss & Corbin, 1990, p. 116). Integration, making it all come together, is most difficult. This level of integration is “not much different than axial coding, it is just done at a higher more abstract level of analysis” (p.117). This is done in several ways, including:

1. Explicating the story line;
2. Relating subsidiary categories around the core category by means of the paradigm;
3. Relating categories at the dimensional level;
4. Validating relationships against the data; and
5. Filling in categories that may need further refinement and/or development (Strauss & Corbin, p.117-118).

These steps are presented in a linear sequence, but in reality the researcher moves back and forth among them.

The fifth component of ground theory method is memos and diagrams. Memos serve as reminders or sources of information. There are three types of memos, code notes, theoretical notes, and operational notes. Beginning researchers are urged to maintain division among types of memos to avoid exclusion of valuable information. Diagrams are visual representations that show the evolution of the logical relationships between concepts. At the beginning memos and diagrams may appear awkward and simple, should be dated, and include a reference. As analysis progresses, modification reflects clarity in thought about relationships of concepts and categories (Strauss & Corbin, 1990).

Credibility of Findings/Trustworthiness

The traditional scientific cannons used to evaluate research findings are inappropriate to evaluate the naturalistic paradigm. Lincoln and Guba (1985), note four basic areas “truth value“, “applicability”, “consistency“, and “neutrality” address the questions of trustworthiness. They provide alternatives to conventional terms, addressing trustworthiness, “that provide a more logical and derivative
relation to the naturalistic axioms” (p.301). Therefore, the terms “credibility”, “transferability”, “dependability”, and confirmability” are the naturalist’s equivalents for the conventional terms “internal validity”, “external validity”, “reliability”, and “objectivity” (p.300). They contend that “different basic beliefs lead to different knowledge claims and different criteria” (p. 294) therefore, qualitative studies should be judged using criteria that are developed for and fit the qualitative paradigm. Table 3.1 illustrates measures for ensuring trustworthiness in qualitative research.

The researcher is a major instrument by which to increase the probability that credible findings will be produced. There must be investment of sufficient time to learning the culture; to test for misinformation introduced by misrepresentations from either self or respondents; and for building trust. The researcher must be sensitive to perceptual distortions from the respondents, any misconstruction of investigator’s questions, as well as answers given by informants wanting to please the investigator. Building trust is time consuming, but demonstrates to the respondents that what they say will be held in strict confidence and will not be used against them; that they will remain anonymous to by all who view the data. Trust must be demonstrated continuously during the inquiry process, in order to honor the interests of the respondents.
The more time and energy the investigator spends in becoming close to local culture, the more accepted he or she becomes. Here lies the danger that the
Table 3.1
Measures for Ensuring Trustworthiness

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Criteria</th>
<th>Applicability</th>
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<tbody>
<tr>
<td>Credibility</td>
<td>Increase</td>
<td>Prolonged Engagement</td>
</tr>
<tr>
<td></td>
<td>Probability of Credible Findings</td>
<td>Persistent Observation</td>
</tr>
<tr>
<td></td>
<td>Peer Debriefing</td>
<td>Triangulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Process helps keep the inquirer “honest”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Biases are probed, meanings explored</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opportunity to test working hypothesis</td>
</tr>
<tr>
<td>Negative Case</td>
<td>Objective is to</td>
<td>Continuously refine hypothesis until it accounts for all known cases without exception</td>
</tr>
<tr>
<td>Analysis</td>
<td></td>
<td>Referential Adequacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Investigator archives portion of data and then recalls it when tentative findings have been reached</td>
</tr>
<tr>
<td></td>
<td>Member Checks</td>
<td>Summary of interview “played back” to person providing it or another respondent who is asked for opinion</td>
</tr>
<tr>
<td>Transferability</td>
<td>Thick description of sample</td>
<td>As assistance for interested party to contemplate duplication of study</td>
</tr>
<tr>
<td></td>
<td>Confirmability Audit</td>
<td>Audit to authenticate the process, coding</td>
</tr>
<tr>
<td></td>
<td>Audit</td>
<td>Raw Data</td>
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<tr>
<td></td>
<td></td>
<td>Data Reduction and Analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Reconstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Process Notes</td>
</tr>
</tbody>
</table>

(Lincoln & Guba, 1985)
researcher will over identify with the informant, that the researcher will lose his or her professional judgment. The researcher must remain alert to this possibility for he or she must be able to sort out what counts and what doesn’t count. He or she must be able to describe in detail how the exploration is carried out if trustworthiness is to be accomplished (Lincoln & Guba, 1990). The investigator’s use of a journal to record a variety of information augments trustworthiness. This journaling consists of “1) the daily schedule and logistics of the study; 2) a personal diary providing an opportunity for reflection upon what is happening in terms of one’s own values and interests, and for speculation about growing insights; and 3) a methodological log in which decisions and rationales are recorded” (Lincoln & Guba, 1985, p. 327). The schedule and personal diary require daily entries, which the methodological log entries are as needed.

Methods

The next section discusses sample selection, description of sample, sample description of acculturation and ethnicity, recruitment, procedures and operations, data collection, data analysis and trustworthiness.

Sample Selection

Subjects were selected with the following inclusion criteria.
1. Caregiver was over 21 years of age.
2. Caregiver was related to a community-dwelling elder through consanguinal or acquired kinship ties.
3. Caregiver provided at least one intermittent service to the elderly person, without being paid at least once a month.
4. Caregiver was living within a 50-mile radius of the elderly individual.
5. Caregiver self identified as Mexican, Mexican-American or Chicano.
6. Caregiver was willing to participate.

A total of twelve subjects were recruited for the study. Two subjects were dropped. One subject changed her mind about participation when the researcher arrived for interview. For the other, during the interview, it was discovered the subject had just been approved for financial reimbursement for taking care of elder and therefore did not meet inclusion criteria for this study.
Description of Sample

Demographic information was obtained for this study (Appendix C). All 10 caregivers were female, 7 were daughters, 1 was a granddaughter, 1 was a daughter-in-law, and 1 was a niece.

Table 3.2 shows the age of the caregiver, the age and gender of the elder, and the duration of the caregiving experience at the time of the study.

Seven elders lived with the caregiver in the caregiver’s home; one lived with the elder in her home; and two elders lived in their own homes, one with a spouse and one with a son.

Religious preferences for the caregiver and the elder were identified by the caregiver. Eight caregivers identified themselves as Roman Catholics, one was Pentecostal, and one reported no religion. Seven elders were identified as Roman Catholics, two as Christian, and one as Pentecostal.

Table 3.3 reflects the educational preparation for the elder and the caregiver.
Table 3.2
Description of Caregivers, Elders, and Duration of Caregiving Situation

<table>
<thead>
<tr>
<th>Age of Caregiver</th>
<th>Age/sex of Elder</th>
<th>Duration of Caregiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>59 yr./female</td>
<td>7 years</td>
</tr>
<tr>
<td>50</td>
<td>84 yr./female</td>
<td>6 years</td>
</tr>
<tr>
<td>58</td>
<td>90 yr./female</td>
<td>14 years</td>
</tr>
<tr>
<td>52</td>
<td>80 yr./female</td>
<td>30 years</td>
</tr>
<tr>
<td>50</td>
<td>70 yr./female</td>
<td>15 years</td>
</tr>
<tr>
<td>59</td>
<td>94 yr./female</td>
<td>3 years</td>
</tr>
<tr>
<td>38</td>
<td>68 yr./female</td>
<td>2 years</td>
</tr>
<tr>
<td>42</td>
<td>63 yr./female</td>
<td>13 years</td>
</tr>
<tr>
<td>54</td>
<td>77 yr./female</td>
<td>1 year</td>
</tr>
<tr>
<td>51</td>
<td>94 yr./male</td>
<td>6 years</td>
</tr>
</tbody>
</table>
Table 3.3

Educational Preparation of Elder and Caregiver.

<table>
<thead>
<tr>
<th>Education</th>
<th>Elders</th>
<th>Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 8 years</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>&lt; 12 years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>High School</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Technical or Vocational</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Some College</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Associate Degree</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bachelor Degree</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Some Graduate</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
Description of Acculturation and Ethnicity

Subjects were asked to self identify their ethnicity and that of the elder. An open question was used to allow the subject to self elect freely the identification label. Table 3.4 summarizes the generational and ethnic description of the sample. There were two second generation caregivers; four third generation caregivers; and three fourth generation caregivers.

Recruitment

The aim of this study was to recruit a sample of Mexican American caregivers from the community. Following Human Subjects Committee approval (Appendix D), the sample was recruited by community outreach, word of mouth and the snow ball technique. Outreach workers were asked to identify possible subjects within the community, who identified themselves as Mexican, Mexican American or Chicano. Potential subjects were approached by community liaisons for possible participation in the study (Appendix E). Those who agreed to be contacted by the researcher provided their names and telephone numbers to community liaisons. Potential subjects were contacted by telephone by the researcher, and the study was explained in detail.
Table 3.4
Generational and Ethnic Description of Caregivers

<table>
<thead>
<tr>
<th>ID</th>
<th>Self Identification</th>
<th>Elder</th>
<th>Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Chicano</td>
<td>Mexican</td>
<td>1\textsuperscript{st}</td>
</tr>
<tr>
<td>PJ</td>
<td>American</td>
<td>Mexican American</td>
<td>3\textsuperscript{rd}</td>
</tr>
<tr>
<td>SM</td>
<td>Mexican American</td>
<td>Mexican</td>
<td>2\textsuperscript{nd}</td>
</tr>
<tr>
<td>MK</td>
<td>Chicano</td>
<td>Mexican</td>
<td>3\textsuperscript{rd}</td>
</tr>
<tr>
<td>TW</td>
<td>Mexican American</td>
<td>Mexican</td>
<td>2\textsuperscript{nd}</td>
</tr>
<tr>
<td>YF</td>
<td>Mexican American/</td>
<td>Mexican</td>
<td>4\textsuperscript{th}</td>
</tr>
<tr>
<td></td>
<td>Hispanic/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mexican</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GD</td>
<td>Mexican American</td>
<td>Mexican</td>
<td>4\textsuperscript{th}</td>
</tr>
<tr>
<td>NB</td>
<td>Mexican American</td>
<td>Native American</td>
<td>4\textsuperscript{th}</td>
</tr>
<tr>
<td></td>
<td>/Mexican</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WS</td>
<td>Hispanic</td>
<td>Mexican</td>
<td>3\textsuperscript{rd}</td>
</tr>
<tr>
<td>ZQ</td>
<td>Mexican American</td>
<td>Mexican</td>
<td>3\textsuperscript{rd}</td>
</tr>
</tbody>
</table>
Interviews for caregivers willing to participate were scheduled at a time and place of their choosing.

Procedures/Operations

The nature of the study required that each subject sign a consent form. The consent form provided a description of the study, the risks and benefits of the study, the extent of subject involvement, and a statement regarding the rights of the subject to withdraw from the study. Consent forms were provided in English and Spanish (Appendix F; Appendix G). All subjects chose the English consent form. Next they were asked to answer questions on a short demographic form (Appendix C) provided in English and Spanish. The demographics provided the in-depth description of the sample. Subjects were advised that interviews could be conducted in the language of their choice, English or Spanish, or both. All subjects chose to be interviewed in English; therefore there was no need for translation and audit for translation accuracy by an independent reviewer. All subjects were asked a total of 31 questions (Appendix H) that addressed:

- Historical time—the changing demography of family,
- Kin Time—family obligations defined by economic, social, physical, and psychological family needs,
- Peer Time—synchronicity with friends and colleagues,
• Intergenerational time—the timing of entry into the caregiving role
• Social Service Time—the use of outside agencies to help with caregiving
• Ethnicity—generational status of elders, and
• caregiver’s ethnic self identification.

Interviews were audio taped and this researcher transcribed all interviews removing all subject identifiers.

Data Collection

Data from ten subjects were collected and used for this study. Subjects were assigned numbers and pseudo initials beginning with #100/CC. All recordings were reviewed following each interview and transcribed. All transcriptions were compared to the recording and audited for accuracy. Interviews were transcribed and analyzed in interview rounds. This allowed the emergence of categories prior to conducting the next interview. The entire process was comprised of seven interview rounds. Table 3.5 identifies the interview rounds and the interviews identified by pseudo initials, at each round. Transcription of the first two was followed by open coding. At this time, there was inconsistency in themes observed. It was decided to obtain interview #102/SM and after transcription, and coding, these codes were compared and contrasted to the
first two. It was noted that #101/PS and #102/SM contained more similarities with each other than with #100/CC. At this time #100/CC was set aside as a possible contrast case. In subsequent stages, the same procedure was followed, and each time codes from all interviews were compared and contrasted with each other and with #100/CC. At the end of seven interviews, it was decided that #100/CC would remain as the contrast case.

Interviews

Interviews were scheduled and lasted from 45 to 90 minutes. Six were conducted in the subjects’ home; two were done in the subjects’ work office; one was done in a quite area of a waiting room; and one was done in a restaurant. Three interviews were interrupted by either
Table 3.5

Data Collection Interview Rounds

<table>
<thead>
<tr>
<th>Interview Round</th>
<th>Transcription/Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1</td>
<td>Interview CC, PS</td>
</tr>
<tr>
<td>Round 2</td>
<td>Interview SM</td>
</tr>
<tr>
<td>Round 3</td>
<td>Interview MK, TW</td>
</tr>
<tr>
<td>Round 4</td>
<td>Interview YF</td>
</tr>
<tr>
<td>Round 5</td>
<td>Interview GD</td>
</tr>
<tr>
<td>Round 6</td>
<td>Interview NB</td>
</tr>
<tr>
<td>Round 7</td>
<td>Interview WS, ZQ</td>
</tr>
</tbody>
</table>
family needs or elder needs. The interview done in a restaurant was the most difficult due to multiple interruptions and a high noise level. Home interviews allowed for better observation of the home environment that was beneficial for ethnicity determination. With the exception of the restaurant setting, all other interviews were conducted in a private setting that allowed for open questions to be posed while maintaining privacy for both interviewer and informant.

Data Analysis

Analysis of transcribed interviews using grounded theory methodology incorporated a system of analytic steps. The method was a repetitive process; the researcher returned to data sources, constantly checking aspects of the emerging interpretations and continued to explore and gather new data.

The first basic procedure was to formulate questions that would address the concepts of the temporal axis (historical, kin, peer, intergenerational time) (Figure 1.1). Initially 24 set of questions were used. After interview three, these were adjusted to 31; seven questions were added to cover the areas believed to be missing. The interview guide was helpful for covering all essential areas of interest, while not imposing too much structure in the
interview, enhancing the free flow of information from the subject.

The second basic procedure was that of making comparisons. This included not only comparison of incident to incident in order to classify them, but also to make use of theoretical comparisons that stimulated thinking about properties and dimensions that provided direction to theoretical sampling (Strauss & Corbin, 1998). Glaser and Strauss (1967) describe four stages in the constant comparative method: "1) comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting the theory, and 4) writing the theory" (p. 105).

The analyst began by coding each incident in the data into as many categories of analysis as possible. Initially transcriptions were formatted and entered into ATLAS.ti computer software program that offers a variety of tools for qualitative analysis of large bodies of textual, graphical and audio data (ATLAS.ti User's Manual, 1997). Statements were broken down and coded. The coding for this data began following the first two interviews and data were open coded for major ideas in paragraphs. The open coding labeled phenomena conceptually, to stimulate thinking about the overall message in order to develop categories in terms of their properties and dimensions. For example, the category of "caregiver at an early age" emerged quickly from
comparisons of caregivers’ responses to the question of “tell me about other family members who have been caregivers”. Each unit of analysis was defined and then compared to every other unit of analysis, so similar phenomena were given the same name or code. Open codes were reviewed in conjunction with memos from initial impressions post interviews, as well as other times of reflection, in order to stimulate thinking regarding categories. This process occurred repeatedly as this researcher returned to open codes to reassess perceptions or when the data appeared it might have a different meaning than that which had already been established by the code.

As the coding continued, the constant comparative units changed from incident to incident to comparison of incident with properties of the category that resulted from the initial comparisons of incidents, for example “caregivers assisting with care of others” was compared with the properties of “early age experience”. Integration of the data was accomplished in several ways. First the story line was developed; second, categories were related to the core category; third, relating categories at the dimensional level; and four the validating relationships against the data (Strauss & Corbin, 1990).

Categories and interpretations that emerged from interviews, cumulatively at each stage, were used in subsequent interviews for verification, correction, and/or
challenge. This researcher maintained multiple memos following interviews, memos while reviewing interviews and memos when reviewing journal entries. There were multiple reflections that were never documented as they happened at times when pen and paper were not readily available. As a beginning researcher, the organization of memos proved to be challenging; the process could have been organized somewhat more efficiently in order to maximize the process. Thoughts, reflections, experiences, findings, and decisions were systematically explored in the literature. The literature allowed this researcher to discover relevant categories and relationships among them, to create new categories in new ways and to explain the phenomenon as it evolved during the research. On-going literature review was utilized as validation and exploration of new concepts as they emerged from the data. By constantly stepping back and asked the questions, what is really happening, does what I see fit the reality of data, this researcher strived to maintain an attitude of skepticism. All explanations, categories, hypotheses and questions about the data, made directly or indirectly from the comparisons, the literature or from experience, were regarded as provisional. The basic questions Who? When? Where? What? How? How Much? and Why? were constantly asked. Findings were at times discussed with noninvolved nursing professional peers for challenge to design next steps, and to conceptualize. This was done
repetitively while making constant comparisons that stimulated thinking about properties and dimensions that provided subsequent direction.

A word processing program, instead of Atlas.ti, was used for merging coded data towards the generation of comprehensive categories. This same program allowed for easier naming and re-naming of categories, than with Atlas.ti. With every revision, data categories were compared and contrasted with each other. Memos and diagrams were found to be very valuable as they served as reminders of sources of information. Throughout the process memos were instrumental in keeping track of how thoughts developed. Diagrams, visual representations, were utilized to assist in the evolution of the logical relationships between concepts. As the process progressed, modification reflected clarity in thought about relationships of concepts and categories to other categories. After multiple adjustments to the model, the data fit the grounded theory that emerged and is presented in this paper.

Establishing Trustworthiness

Because this researcher is a second generation Mexican American and well versed in the culture, it was not necessary to invest a great deal of time to learn the culture. Thought, consideration and planning were invested in strategizing how to build and retain trust from the
subjects. The researcher fully acknowledged the possibility that because there was a common culture with the subjects, that the credibility of findings might be questioned. Prior to beginning interviews, a detailed journal entry of the researchers own values and constructions was written. This initial journal entry was especially important; to avoid any commitment to preconceived ideas of what would be found. The investigator’s use a journal to record a variety of information augments trustworthiness (Lincoln & Guba, 1985). Glaser and Strauss’ (1967) believe that if the researcher remains open and sensitive to the data and what it is saying, theory will truly emerge. Professional experience was another source of sensitivity for this researcher as a result of having previous experience with interviews of caregivers on other studies. This familiarity afforded this researcher some knowledge, although limited, of how caregivers spoke of their experience. The researcher was sensitive to any distortions from the respondents, any misconstruction of investigator’s questions. Responses to open questions at times answered multiple areas of interest; this allowed a free flow of information, minimizing the possibility of informants saying something just wanting to please the investigator. Only decisions concerning initial collection of data were made prior to beginning. Frequent journal entries were made reflecting thoughts, observations,
findings, and experiences. These in turn were explored in the literature in order to make decisions of how to proceed. It was emphasized to respondents that the information they provided would be held in strict confidence, would not be used against them and that not even the dissertation advisor would know who they were. Much detail has been provided regarding procedure as well as data quotes in order to afford the reader to decide for him/herself the trustworthiness of the study.

Member Checks

Member checks did not pose any problems. Since the contrast case occurred at the beginning, it was not until the end of the third interview, that concepts began to emerge. Clarification and validation was accomplished by restating to the subject immediate reflections that later formed into categories. At the end of interview round 3, which was interview TW, subject SM was contacted and findings were shared for validation and feedback. At the end of interview WS, subject SM was once more contacted for validation and feedback. When the final theory emerged, arrangements were made with two volunteers, to validate the emerging theory once more. One volunteer was a third generation Mexican American daughter who had provided care to her mother prior to the death of the elder. The second one, a first generation Mexican was currently providing care
for her mother. Both volunteers validated the theory
categories and phases. The intent was to ensure that the
theoretical pattern developed had “fit” and “grab” for
individuals experiencing caregiving (Glaser, 1978), as well
testing the transferability of the theory.

Peer Debriefing

Thoughts, reflections, and possible conceptualizations
from data were discussed with peer professionals. Units of
analysis, substantive categories, and emerged theory were
reviewed by a peer researcher for content, consistency, and
validity, as well as discussion of possible future research
directions.

The grounded theory’s credibility was addressed through
member checks with subjects already involved in the study.
The theory’s trustworthiness and transferability was
assessed by presenting the theory to two caregiver
volunteers. Responses from everyone were positive. The
subjects understood the theory, and the volunteers were able
to apply it to their own experiences. Therefore, there is
reason to believe the theory is trustworthy, credible,
transferable, and could be useful.

Assessment of Acculturation, Ethnic Identity

Acculturation level was determined by generation,
preference of spoken and written language, and customs
associated with holiday celebrations. Ethnic identity which
is composed of self-identification, a sense of belonging; attitudes about one’s group membership, and ethnic involvement in cultural practices and attitudes, was analyzed according to Keefe and Padilla (1987) typology. This was done in two steps. First, Keefe and Padilla view education level as strongly related to types of ethnicity. For this reason, subjects were assigned type of ethnicity according to their educational level. For example, education less than 12 years was assigned a type one ethnicity, La Raza.

Second, Keefe and Padilla ascribe certain characteristics of each ethnicity type. For this reason, subjects were assessed according to the characteristics by type described by Keefe and Padilla (1987).

The most frequent marker of acculturation is generation; however, generational status does not reveal how “specific changes, such as language acquisition and loss, changing social networks, and evolving cultural values relate to ethnic identity” (Phinney, 2003, p. 64). Phinney notes that measurement of the relationship among aspects of acculturation and ethnic identity is not straightforward, and that existing measures reveal the confounding of the constructs because the same items are often included in measures of each. For example, ethnic self-identification is central to ethnic identity and often included in acculturation scales, while instruments measuring ethnic
identity include markers such as language. Phinney believes that change is “central to an understanding of both ethnic identity and acculturation” (p. 63). This can be a complex undertaking since ethnic identity is not static, but rather subject to change over time or across generations, in different contexts and with age development. Changes occur during lifetimes as individuals adapt to new situations and balance demands and expectations of an old and new culture. Because this study focused on discovering understandings regarding who and when family members participate in the caregiving experience as well as the changing family structure and its effect on caregiving, the measurement of acculturation and ethnic identity was accomplished qualitatively by having subjects share their life history as they associate it to their caregiving role. This approach captured the uniqueness of the individual as well as the unique nature of life circumstances (Ramirez, 1983) which help shape the caregiving experience. The open-ended questions were designed to cover a brief history of the caregiver’s life, family composition and personal support network (which included relatives, friends, neighbors, coworkers, as well as persons seen regularly), the caregiver’s integration into the larger society (use of health care services and recreational pastimes), and their participation and identification with Mexican American culture (Keefe & Padilla, 1987).
There are five types: LaRaza, Changing Ethics, Cultural Blends, Emerging Americans and New Americans.

Summary

This chapter described the methodological approach used to obtain data for this research study. Symbolic Interactionism was described in the first section. Grounded theory method was described in the second section. The third section provided criteria for sample selection, description of sample, and recruitment procedures. Procedures/operations including data collection, data analysis, and analytical procedures, as well as the process used to establish trustworthiness; member checks, and peer debriefing were discussed. The final section described key markers used to identify generational status and ethnic identity data.
CHAPTER FOUR
RESULTS OF DATA ANALYSIS

The goal of this research study was to generate a model that meets interrelated properties for practical applicability. This model should closely fit the substantive area of caregiving; be understandable by health care professionals concerned with this area; be sufficiently general to be applicable to diverse daily situations within this substantive area; is flexible, allowing for revision of the application of the model (Glaser & Strauss, 1967).

This chapter presents the results of the analysis of data generated from interviews with Mexican American caregivers. These interviews concerned how caregivers viewed their role in terms of 1) changes within the family or generational attitudes about caregiving (historical time); 2) shared understandings among family members regarding who and when certain family members would assume the caregiving role (kin time); 3) patterns of temporal synchronicity in which friends or colleagues of the caregiver engaged in caregiving roles of their own (peer time); and 4) timing of entry into the caregiver role (intergenerational time).

The chapter is organized in the following manner. The explanation of the grounded theory follows the model diagram in Figure 4.1. There are four phases to the grounded theory of role acceptance of Mexican American caregivers. All four
phases are defined, followed by examples from the data. Table 4.1 is included to show how the categories are evolved from the data. Description of generational and ethnicity status is provided. Next familism is discussed in context of the caregiving experience. And finally, hypotheses are proposed.

Data analysis yielded a grounded theory consisting of four phases and fourteen categories. The core category identified was titled Role Acceptance; or how the Mexican American family initiates, nurtures, and passes on the role of caregiver. All categories in the model are related to three aspects of the core category of Role Acceptance: Role Making, Role Recognition, and Role Execution (Figure 4.1). Table 4.1 shows how the categories evolved from the data.
Table 4.1
Grounded Theory: Role Acceptance, Substantive and Theoretical Categories

<table>
<thead>
<tr>
<th>Substantive Categories</th>
<th>Theoretical Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase One: Introduction</strong></td>
<td><strong>Phase One: Introduction</strong></td>
</tr>
<tr>
<td>Caregiver at an Early Age</td>
<td>Early Age</td>
</tr>
<tr>
<td></td>
<td>Responsibilities</td>
</tr>
<tr>
<td>Observed Care by Others in Past</td>
<td>Past Observed Caregiving</td>
</tr>
<tr>
<td>Help from Others in Past</td>
<td>Past Kin Help</td>
</tr>
<tr>
<td><strong>Phase Two: Role Reconciliation</strong></td>
<td><strong>Phase Two: Role Reconciliation</strong></td>
</tr>
<tr>
<td>Messages of Who Should Do It</td>
<td>Role Assignment</td>
</tr>
<tr>
<td>Good &amp; Bad Care</td>
<td>Acceptable Family Conduct Transition</td>
</tr>
<tr>
<td>In Between</td>
<td></td>
</tr>
<tr>
<td><strong>Phase Three: Role Imprint</strong></td>
<td><strong>Phase Three: Role Imprint</strong></td>
</tr>
<tr>
<td>Taking it On</td>
<td>Embracing the Role</td>
</tr>
<tr>
<td>Others Caregiving</td>
<td>Timing of Role Entry</td>
</tr>
<tr>
<td>It’s my Turn</td>
<td>Giveback</td>
</tr>
<tr>
<td><strong>Phase Four: Providing/Projecting Care</strong></td>
<td><strong>Phase Four: Providing/Projecting Care</strong></td>
</tr>
<tr>
<td>Impression on Family</td>
<td>Family Impact</td>
</tr>
<tr>
<td>Impression on Social Life</td>
<td>Social Impact</td>
</tr>
<tr>
<td>Feelings About Future</td>
<td>Projecting Future</td>
</tr>
<tr>
<td>Current Help from others</td>
<td>Current Kin Help</td>
</tr>
<tr>
<td>Talk with Next Generation</td>
<td>Dialog with Next Generation</td>
</tr>
</tbody>
</table>
Figure 4.1: Grounded Theory: Mexican American Temporal Axis Caregiving, Theoretical Category Names
In this model, Role Making was defined as instances where caregivers were introduced to and began to anticipate the caregiving role incorporating concepts of tradition and family accountability. Role making was interactive and required input from the elder and from the caregiver.

Role Recognition was defined as instances when caregivers consciously clarified and interpreted the messages they had received during the role making phase. This clarification and interpretation served to crystallize and personalize the role.

Role Execution was defined as instances when caregivers reviewed their performance and compared it with the elder’s as well as their own needs, desires, and expectations. This evaluation continuously occurred, providing direction for future decisions.

**Explanation of Grounded Theory**

Figure 4.1 represents the caregiving role processes of Mexican American caregivers. There are four phases of the caregiver’s role acceptance identified by the grounded theory: Introduction, Role Reconciliation, Role Imprint, and Providing/Projecting Care. The first two phases are related to Role Making. The third phase is related to Role Recognition. The fourth and last phase is related to Role Execution. The model is discussed in relation to these phases of role acceptance.
Phase One: Introduction/Early Caregiving Experiences

Introduction/Early Caregiving Experiences is defined as a time during which caregivers become acquainted with expectations related to the caregiving role. This phase is characterized by experiences the caregiver had in the past. Phase one involves recollections of experiencing responsibilities at an early age, of observation and participation in caregiving with other members in the family. Data underlying phase one reflected times remembered as significant periods of family need when family members did their part, working together to care for those in need. For most caregivers' memories and experiences served as the introduction to the caregiving role they were actively performing. Within this category there are three areas: Early Age Responsibilities, Past Observation of Caregiving, and the overall past assistance of other family (kin) members (Past Kin Help).

Early Age Responsibilities

Early Age Responsibilities was defined as instances at an early age when the caregiver became responsible for providing assistance to family members. Some data related to providing care to other siblings. For example,
YF: “I started at 13 caring for my mom and my brothers and sisters”; “I was 10 years old when he [father] passed away, when he died, I helped.”

Some data related to providing parenting to a parent. For example,

SM: “my mother ...not a real strong person...even way back...I guess all this time [before father left mother] my father was making all the decisions...I remember the people down the street were having a party and she didn’t know what to do, should I go, should I go...what should I wear, I wrapped the present, and wrote the card, just like sending my little girl to a party”.

Some data related to needing to accompany parents and providing translation. For example,

MK: “ever since we were young, because my parents didn’t speak much English...we were responsible for translating, I remember translating with my mom with her doctor’s appointments, when I was 10, 12 years old.”

GD: “...grandmother, I remember that I used to take her to her doctor’s appointments...she passed away 16, 17 years ago. Yeah, translate and I would go cause I would drive her.”

Some related to caring for an elderly relative such as the caregiver who interrupted her education to help her mother take care of grandma;

PS: “I went to school, then I stopped going to school when [grandmother] got sick. I was in college, so I stopped for two years, to take care of her she had heart surgery, so when she left to go to California, to live with her other sister, I went back to school.”

An essential characteristic of Early Age Responsibility were the caregiver having first hand experience.
Past Observation of Caregiving

Past Observation of Caregiving was defined as instances when caregivers observed other family members, mostly mothers, providing care to those in need. Some caregivers remembered how mothers, and aunts took care of “grandmother” by cooking food, arranging for doctor’s visits; of “dad’s sister” suffering from cancer and living in the same household until her death; of mom traveling just to take care of her ill stricken sisters; of grandmother and grandfather living on the same property and mother watching over them and helping with a variety of tasks. These early caregiving experiences provided the expectation of what caregiving should be.

MK: “I saw caregiving pretty much since I was a small child, my aunt in Mexico …I saw her caregiving to other people, relatives and things like that. My mother was a caregiver for my aunt … I saw that happening all the time…”

Essential characteristics of Past Observation of Caregiving included other family members serving as role models and the caregivers having caregiving examples early in their lives.

Past Kin Help

Past Kin Help was defined as instances in the caregiver’s childhood or in years prior to the current caregiving situation which reflected collective labor expected of family members to endure in time of need. Some
data reflected a feeling of solidarity with other members of the family, of not experiencing any great burden, in doing what needed to be done; of helping out and of having others in the family do their part.

PS: "it didn’t [interfere] cause my sisters all of them used to help out a lot, everybody did a little bit and nobody felt like they couldn’t do what they wanted. ...my mom was able to take care of her, she never felt like ...didn’t feel like your life had been put on hold."

GD: "when my grandmother needed, he [brother] would also drive her places…"

"...the weekends ...that’s when my other sisters and brothers would go cause I would go there during the week, so I still like had my free time during the weekend."

TW: "We [sisters and brother] talked about it, I said I’ll take care of grandma and you take care of mom cause I can’t do both. ...now they’ve taken charge...and we report to each other what’s going on."

CC: "she did not need very much care...We [took care of her] , or [her daughter] –When she was down there...We [would] keep in touch."

Other data in this category reflected a feeling of being alone and of siblings not understanding the need to help out. For example,

TW: "not very much [help], my sister was very involved with her work and so was brother...my brother would come over on Sundays and sit with my mother for a few hours but he couldn’t provide any of the personal care or anything, so I pretty much did all of that…”

ZQ: "...it was just that most of the time my siblings did not even know she was sick...they weren’t really involved...they wouldn’t do anything if I needed it...they never came by or helped out."

Data show no observable reason for some family members providing help and others none. Essential characteristics
of Past Kin Help were family members sharing responsibility and mutual respect in the past.

Phase one is the starting point of the role making process. During this phase, the caregivers are introduced to the caregiving role and their experiences begin to create a self-conception of “caregiver” and an understanding about what this interactive behavior involves.

Phase Two: Role Reconciliation

Role Reconciliation is defined as a time when caregivers acknowledge on a conscious level their agreement regarding their role as a caregiver in addition to their role as a daughter, granddaughter, or niece. Phase two is part of the role making process because in this phase caregivers continue to define and redefine the merging of caregiver and daughter (or granddaughter, niece) identities. These definitions provide the caregivers with the logical arguments in making the decision to take on the role. There are three categories in this phase, Role Assignment, Acceptable Family Conduct, and Transition. The first two categories relate to messages the caregivers received during their growing up period. These messages provided justification for who was selected to perform the caregiving role, and what kind of family conduct was considered acceptable. The third category relates to the time between
the caregivers’ assigned role and when they assumed the role.

Role Assignment

Role Assignment was defined as instances when caregivers received explicit or implied messages that the caregiving role was ascribed to them. Caregivers indicated they had been given the message throughout their lives; that certain behaviors were expected because they held a different place within the family. These caregivers knew they had been chosen for the caregiving role because they were the “oldest”, or the “youngest”, or the one in the “middle”. They could also have been the one who never married, or the one who was not currently married; or they could have been the one who always got along with the elder or the one whose job was not as important as other children in the family.

PS: “Not that I was the one, but I knew that I would have to...because I am not married, everybody else was, or has been married...”

MK: “My brother ...he’s a guy...never really held responsibility for any caregiving...I was the middle child...my younger sister; she has issues of her own. I’m single; I don’t have any children ...”

TW: “I’m not married, and I don’t have a family at home, I have a daughter but she’s grown and gone, so I feel I have more time and energy to give my parents.”

SM: “...my sister and her have never had a good relationship, they’re too much alike, and so they kind of butt heads all the time... my personality and my willingness to do it and I get along.”
Essential characteristics of Role Assignment were designation by other family members and the individual feeling responsible.

Acceptable Family Conduct

Acceptable Family Conduct was defined as messages received throughout life about what was valued within the family when it came to providing assistance.

NB: "I come from a family who has always taken care of the elderly in the family.”
"...I was raised to accept your family and you open your doors to everybody.”

MK: [talking about siblings] “even though we have our lives, we were raised that way...we’re there” [for each other].

TW: “that’s the way I was raised, I mean both my grandmothers from both sides were taken care of by the family and I just feel that there’s a real strong tie when it comes to family relationships.”

Explicit messages, as well as personal observations regarding undesirability of care by non-family, supported the caregiver’s decision to maintain the elder at home as long as possible, hopefully until death.

SM: "...she started telling me early on that she did not want to go to a nursing home. She said they’re mean to you, las avientan [they shove you] they this and that so ...like don’t do that to me.”
[elder in a home for three days] “she [elder] was just sitting there with her little head down in the wheel chair with her lips dry...and she seemed like she had no children, ...anybody [that] saw her would say this woman has no children, she doesn’t have any children.”
ZQ: "...that was her request not to be put up somewhere...It’s a fear of being put somewhere and being forgotten. It was my grandfather who said ...as long as you have family, there’s no reason to put him away. It’s like putting him with strangers."

MK: [elder] "went to visit my nina, [caregiver’s godmother] ...at the nursing home and [elder] was not too happy with what she saw."

Essential characteristics of Acceptable Family Conduct related to what was permissible, reasonable, and appropriate behavior and what was expected.

Transition

Transition was defined as a time that finds the caregiver waiting for the elder’s condition to worsen thus intensifying the need for hands on care. During this time, caregivers were independent, going to school, married, having children, working, and living outside the parental home. Even though they are out on their own, the family responsibilities continuously drew them back. During this time, the chosen individual adjusted and/or conformed to the demands the role would place on them in later life.

PS: "...went to live with [twin], ... even then when I was living over there, I always came back here...cleaned, made dinner, went to school or to work."

NB: "...family that if it isn’t one side, it’s the other side, that have this type of common culture or whatever you want to call it. I tried to pull away from that type of lifestyle, this cycle, and it’s very difficult, because there’s always people trying to pull you back in."
It was during this time that undeniable changes began to occur, changes that represented the increasing role they would play in the care of their elder. If the elder was without a spouse due to either death or to separation and living alone, usually the decision was made for the elder to become part of the caregiver’s household. This decision to live with the caregiver was made by the caregiver, or by the elder. Living together provided mutual benefits. During this time, the caregiver and elder shared household responsibilities such as taking care of children, or cooking the evening meal. At this time the elder required minimal assistance, mostly with doctor’s appointments, sometimes medications, and transportation for shopping.

SM: “When [elder’s live in partner] left her ...she had a mental collapse...physically she was okay, but emotionally...mother said I’m afraid, ... I wanted her to stay in her own house, ... no, no, no, I’m scared, I’m scared. ...then one day, she ...signed and sold it [her house] and that was it...she didn’t have anywhere to go...my mother moved here.”

MK: “after dad passed ...she was lonely and scared, she got scared at night she wasn’t used to being alone, she and dad were married for 52 years, so she had no experience living alone, she left her father’s house to marry my dad. And that was her whole experience”, [elder moved in with caregiver].

NB: “She [elder] had been involved in a car accident with her daughter, and she came to ... get her medical care, ...so she asked if she could stay with us cause we had the biggest house with the most room at that time...she’s been there for 13 years.”

GD: “when dad died ...she [elder] doesn’t drive, she doesn’t like to live alone, we don’t like to leave her out there alone. ...she decides, whatever she wants...she
ends up staying [here] ...even when my dad was alive, cause my dad was in and out of the hospital ...she would stay here once my dad passed away.”

YF: “she [elder] would go and spend three months [with caregiver], at first she would fly, they would put her on a plane and she’d fly and stay there, then it got to the point where ...it wasn’t safe for her to fly by herself, so we’d come pick her up, take her, she would always say if you ever move back, to Arizona, I want to live with you...two years ago, ...made the decision to [return]...retired here.”

WS: “She [elder] was always afraid to be alone. She never had had to be alone. If she was alone, my parents never spent much time apart, they didn’t leave each other. [when father died] I would bring her down, and she would spend a week or two ... then she’d do better and go back. So basically she came for Thanksgiving and she didn’t go back.”

Two caregivers who lived a distance from the elder, more than 800 miles away, moved into close proximity of the family prior to the caregiving experience during transition. When asked if their sole reason for moving back was to take care of their elder, they denied doing this, instead citing the reason for their move was just to be close to family.

ZQ: "...went away ...when younger...moved to El Paso when I was 25 ... it just happened...close to grandmother ...then I moved to san Francisco, and shortly after that moved back to Tucson...my entire family was here and that was really the only thing, and that was a hard decision...I wanted to be close to my family.”

YF: " I came two years ago, I lived in California, and we came back because of family...family issues, we didn’t have anybody except for my son in California, and we started realizing...we needed the family, and my daughter got transferred...so we made the decision to [return]...retired here.”

Because caregiving is performed in numerous levels of intensity, the period of transition extends from care
activities delivered in an accommodating, cooperative relationship to one that is overwhelmingly demanding of the caregiver. Two of the caregivers were in the low intensity period of the transition phase. In these cases, it was the elders who did not want to live alone and made the decision to move in with the caregiver and their family, one following the death of her husband and the other following an acute need for help which then subsided. Both elders did not require physical care, therefore helped out with the cooking and housework. The caregiver and the elder provided companionship for each other; they shopped together and enjoyed each other’s company, with the caregiver being responsible for transportation for all activities. Both elders were diabetic and required medication; the caregivers oversaw the elders’ adherence with treatment plans and interacted with physicians on behalf of the elders.

Transition was a time when caregivers imagined themselves in the caregiving role. These thoughts provided the definitions of the role that would be played and serve to influence the plan of action. Essential characteristics of transition were adjustment, modification, and anticipation.

Phase two Role Recognition comprises the second part of Role Making. During this phase the caregiver continued to receive messages that contributed to self perceptions about a future caregiving role identity.
Phase Three: Role Imprint

Role Imprint is defined as a time during which caregivers are required to change their behavior in response to changes in the elder’s health. Role Imprint is represented by three categories, Embracing the Role, Timing of Entry, and Giveback. This phase marked a point in the caregiving experience as a time when the needs of the elder intensified. The caregiver acknowledged the need and accepted the responsibility. Although the caregiver had been involved with the elder and provided care, in some capacity prior to this time, this phase found the caregiver comprehending the magnitude of the role they were undertaking. At this time, the caregiver might find solidarity with peers who were doing the same thing.

Embracing the Role

Embracing the Role was defined as the time when caregivers changed their role as a result of the elders’ increasing needs for assistance. Caregivers were prompted by an increased need for assistance and often a significant event. This event in some ways was considered a point of no return.

MK:  “I’ve been responsible for the right care for a long time... [but] Mom was having falls and she was very depressed, so she moved in with me.”
PS: "...it was one hip surgery then the next one and then it was go to the hospital, cause she didn’t mind the doctor."

SM: "we [sisters and caregiver] just knew she wasn’t going to be able to do it much longer...[sisters said] she [elder] doesn’t want to stay[with them] ... she [elder] is mad, she’s this, she’s that, so now she’s ...here since then [about three years]."

TF: "At the beginning...it was going to be that I was going to help my sister, ...once my mom came over here, it seems like everybody forgot, she’s here."

WS: "...she just couldn’t be in a house alone at night; she would not consider getting a stranger to stay with her. She wasn’t sleeping, she was very afraid at night. ...she would still be there, she’d be dead, that’s what she would be...dead ...I couldn’t turn my, I can’t just walk away and not do anything."

Essential characteristics of Embracing the Role were status change of the elder and role acceptance by the caregiver.

Timing of Role Entry

Timing of Role Entry was defined as the time of the role acquisition and its synchronization with peers. At this time, the caregiver either identified with others due to mutual circumstances or felt alone with no one to understand. When caregivers found others, friends and/or other family members were engaged in caregiving, they viewed their own role positively. Most caregivers in this study had friends and family engaged in; caregiving or anticipating becoming a caregiver. This provided for the exchange of common experiences that fostered feelings of
solidarity, therefore allowing the caregivers to view their roles positively.

PS: "They [friends] take care of them [mothers and fathers] ... One of my cousins stays with her father...is there when he needs her. Even friends at work ...so it’s not only me ...my friends are doing the same thing. I get together with them; they understand it a lot better."

SM: "...a lady at work, another her mother just passed away, another takes care of her dad. We talk, yeah, we talk."

MK:" I have four really good friends and they’re all involved in caregiving in one aspect or another. We commiserate...these are friends that were friends before they started to take care of...so the group has moved into it together and I think that’s what kept us sane for the most part."

"...the four of us that do caregiving, we call weekends "mom duty" ...we kind of work around it...my other friends, they don’t understand..."

"...after a while it grates on your nerves...At that point I call somebody and talk they share very similar experiences with their mothers."

TW: "got a friend right now, that is taking care of her mom, she knows...I have a cousin, she was my aunt’s...my aunt died, but she cared for her several years."

"...one of my best friends was taking care of her mother, she passed away, another has a mother in a wheelchair, with diabetes, and she is in charge..."

WS: [those who] “are doing that[caregiving] are not my close friends, ...Increasingly all my friends are finding themselves in a position of either caring for their parent directly or having to make arrangements for them."

ZQ: "some of my friends, that are taking care of elders, have their relatives in their households living with them ...we share the same schedules, we know that our lives consist of taking care of that other person."
Two caregivers did not have any friends or acquaintances taking care of others. One of them was the youngest in the sample, at age 38.

YF: "I can’t think of anybody so I don’t get a chance to talk to others, that’s why I want to get into a support group."

Essential characteristics of Timing of Role Entry were synchronicity with peers, and a sense of harmony with peers.

Giveback

Giveback was defined as a sense the experience was normative that allowed caregivers to make a long term commitment to provide care to the elder. Caregivers stated they needed to give something back to the elder for all the elder had given the caregiver during his/her lifetime.

MK: "my mom took care of us and she was an excellent mother, she taught us a lot of values, and the work ethic and she wanted us to get ahead...she invested a lot of time and effort in us, ...I think it’s my turn to do that."

TW: "mom and dad were always there for me when I grew up, they supported me, they always encouraged me, they’ve always been there for me, and I just want to be there for them...it’s my way to pay them back for being such wonderful parents."

YF: "...she took care of me, now it’s my turn, it’s my responsibility."

GD: "I just knew that someday it would happen ...they took care of us when we were young, it’s our turn now."

ZQ: "it just like thank you for taking care of us, my turn."
Reciprocity served to affirm familial responsibility and the importance of the bond with the elder. Caregivers believed it was a time for them to be there. Essential characteristics of Giveback were the need for repayment, reciprocity, and restitution.

Phase three, Role Imprint, is related to Role Recognition because this is a time when the caregiver becomes aware that the condition of the elder is deteriorating and time has come to accept and assimilate the role.

Phase Four: Providing/Projecting Care

Providing/Projecting Care is defined as a time when the caregiving role is actualized. This phase represented the day-to-day reality of the caregiving experience (i.e. providing care). This was a time when caregivers were faced with the consequences of their decision to accept the role. These consequences were in terms of how and what the family was required to alter, of adjustments in the caregiver’s social activities, of coming to terms with the degree of assistance needed from family and of the awakening to the possibility that the elder’s condition might not allow them to remain at home until death. It was also a time from an intergenerational perspective when the next generation was introduced to the caregiving experience (i.e. projecting the care experience). This phase consists of six categories:
Family Impact, Social Impact, Balancing Feeling, Projecting Care, Current Kin Help, and Dialog with Next Generation.

Family Impact

Family Impact was defined as the modifications that family members made in order for the caregiving role to be executed. Caregivers experienced diminished privacy and intimacy with spouses and children, while children were required to adjust their personal as well as their social lives.

SM: “We might do more things, we have, rarely had family life...I maybe see [oldest son] more often, but [second oldest] we don’t see him very often...I have been thinking about it, and it’s about seeing them.”

NB: “we tell them [the kids] that they can have their friends over, but they have to give us enough time so we can tell my aunt...‘do you want to make arrangements or are you going to stay in the room’ cause the noise in the house really bothers her.”

“it has it’s a lot of tension for me with my husband, he and my aunt do not get along at times, and then with the children, they’re growing up and my other son is rebelling cause she wants to treat him as a child... so it creates a lot of tension.”

ZQ: “now my children are older and I have no little children, so my children can fend for themselves.”

In order for the caregiving role to be actualized, families were required to make various adjustments in their everyday lives. Essential characteristics of Family Impact were realization of consequences, adaptation, and adjustment in family function.
Social Impact

Social Impact is defined as the changes caregivers made in their social lives in order to adjust to the demands of providing care. These changes produced a certain amount of anger and frustration for some caregivers.

MK: "they [friends] have a more difficult time understanding why I am not available to do things with them like I did in the past ...so when I talk to my other friends, they’re not, they’re not, what do I say, they don’t understand, when I say I have to do mom duty, ...so I cancel you know or I say I can’t go, I’ve had to rearrange my personal time to ..."

NB: [I’m] "Angry at her [elder], she’s very young...diabetes...shouldn’t stop us from having our friends over to the house or my son from having his friends and it bothering her."

WS: "that [social life] really hasn’t changed. The biggest change, it’s just been I have to think a little harder, like if I’m going to be gone a period of time then I ...need to make arrangements. I have to think a little bit harder takes a little of the spontaneity away...you just can’t take off at the last minute, you have to think about it."

Others described their social life in terms of family activities, and therefore believed there had been no change.

PS: "my brother he comes at least four times a week, Family life didn’t’ change very much from the time she was well to now, no, we still get together and come and go, so that part hasn’t changed at all."

MK: "we are a very close family unit. Grandchildren very close ... my nieces and other children really close ... [the] grandchildren ...very close to nana [grandmother] ...that whole social ness hasn’t changed at all."

GD: "we all get together all the time, we are close...like where my mom is, if she’s here, they come here, if she’s at my sister’s, we go there."
TW: "I don’t feel it [caregiving] interfering, we work around it...it fits well ...It's not interfering with life...Not, now."

Essential characteristics of Social Impact were social isolation in the case of friends and others outside the family with little effect on socialization with family.

Projecting Future

Projecting Future was defined as a time when the caregiver reflected on their performance while contemplating what they would do if the elder’s condition worsens to a point the caregiver is unable to provide all of care needed. The caregiver’s conscious thoughts reflected how the caregiver maintained the decision to continue to provide care to their elder.

PS: [asked if she would consider getting outside help] "He [father] doesn’t like, want [outside help]...no...if he said okay...maybe like once or twice a week, maybe, but no probably not...[sister] was saying she wanted to bring someone in, but ...Maybe he’ll change his mind...Maybe..."

SM: "It won’t be very much longer ... [sister], wants to put her in a home ...we need to put her in a home,”

MK: "mom has some money...if the time comes we will use that money to keep her at home and have a full time caregiver during the day."

TW: "I’ve talked to both of them, that’s when we got the insurance, they wouldn’t want me to give up my life and just care for them, this way ...I could get caregivers that would help me out."

WS: "if it gets to the point she cannot care for herself any longer, ...I think at that point we will look at some kind of like assisted living ...At that point probably not at home with us. ...So when it is necessary she will have the resources to do it."
ZQ: "I would probably try to get him help at home ... unless he was on a ventilator or something."

Data also reflected the magnitude of the responsibility caregivers felt, knowing that the only way for the situation to change was for the elder to die. This was not something that was readily admitted.

MK: "When I become resentful because of how did I end up with this...I want to run away, and then I recognize it’s only human nature... I have a full time job, I have the responsibility...I try to keep friendships going, there’s a lot on my plate ... I try to put it all in perspective ... try to balance all the parts."

TW: "...They don’t want to be a burden to anyone; we have never said that they would be a burden to take care of."

WS: "Sometimes I feel like at a time in our life, when all of the children are doing well... when it should be easier, it’s not. It should be simpler and it’s not it’s complicated. And it isn’t in a defined way. It’s not going away. The only way it will go away is if she dies, and I don’t want [to] sit there and hope my mother dies."

SM: "I think about her passing away, not that I wish my mother would pass away but pass away, pass away quickly. [sister] says ... Do you realize that you’re keeping her alive, you’re keeping her alive... if it wasn’t for me she would have already died."

Being employed outside the home prompted some caregivers to realize they might need help in the future. Most caregivers wanted to maintain the elder at home, thus gave rise to the idea of needing to accept outside help to assist them in the delivery of care. Only one caregiver appeared to have made the decision to place the elder in a home when the elder could no longer care for herself.
Essential characteristics of Projecting Future were speculation, and forecasting about future eventualities.

Current Kin Help

Current Kin Help was defined as the type of assistance family members currently provided to support the caregiver and the elder. This covered a wide range of activities, such as transportation, getting groceries, and running errands by others in the family.

PS: "I don’t drive, they [brothers and sisters] have to decide who’s going to drive…get groceries, stuff like that, I call them up and say I need this right away, take me, to the groceries."
“There isn’t one [brother or sister] that feels more that they need to do it. It’s just that way it is, that’s the way it is. If I needed something, I wouldn’t hesitate to ask [siblings].”
“If I need something, I call and someone helps out.”

YF: “My husband supports me 100%. …He helps me out; in fact he has no problem.”

The type of help the caregiver wanted was not always available, giving rise to anger and frustration at times.

YF: “…now if I want help, I have to holler.”
“Sometimes she [sister] does [help], and other times its one excuse after another why she can’t…My brother will come and watch her here.”

ZQ: “They [sisters] do not help. I have asked them to … they just seem to be afraid to be with him like he’s going to die on their watch or something, they don’t understand that it will happen it’s not them.”

Data did not show any observable reason why some caregivers were satisfied with the support and assistance provided for by the family, and others were not.
Essential characteristics of Current Kin Help were a sense of sharing responsibility.

Dialogue with Next Generation

Dialogue with Next Generation was defined as messages given to the younger family members regarding future family caregiving. In some instances, there were messages that encouraged the children to decide for themselves what to do, while others set expectations for future caregiving.

SM: “I do tell [daughter] just because I took care of nana, doesn’t mean you have to take care of me. I will be fine in a home, because I like people, and I get along.”

TW: “she[daughter] teases me tells me she’s going to put me in a nursing home, so I tell my grandchildren that they’ll have to not let her ...my grandson says I won’t let her nana, I’ll take care of you I won’t let mom put ...She’s just teasing, truly believe she is,”

ZQ: “...so now that makes the natural progression that as my godfather that I would take care of my godfather and that’s what we’re teaching our children that the godparents are very important and we teach that to our children.”

In some cases, the children of the next generation were already involved in the caregiving of the elder.

MK: “now there’s one granddaughter in particular that spends more time with my mother than the others. Ah, and she just makes it important to do that...so she is very close.”

ZQ: “my older son helps. He’ll take grandpa to his medical appointments if I can’t go, so right now I have support from my son, ...actually if I can’t go for some reason [he]will take grandpa to the doctor, ...[he] reports back and I usually get a call from the doctor.”
Thus, essential characteristics of Dialogue with Next Generation were role modeling, providing directives, experience setting expectations and giving directives, and providing caregiving opportunities and encouragement.

Phase four is related to Role Execution because this is a time when the actualization of the caregiving role is in fully interactive and operational.

Acculturation, Ethnic Identity and Familism

Symbolic interactionism tells us that we learn family cultural patterns that define the content of identities and interactions. “Within every culture there are preferred whos, whats, whens and wheres which are held up as models to be emulated” (McCall & Simmons 1978, p.24). This study focused on discovering understandings regarding who and when family members participate in the caregiving experience as well as the changing family structure and its effect on caregiving; and explored the extent of the influence of cultural values, acculturation, ethnicity and familism. The assessment of acculturation, ethnic identity, and familism was accomplished qualitatively by having subjects share their life history as they associated it to their caregiving role.

Acculturation

Characteristics from Keefe and Padilla’s typology were used to categorize subjects according to ethnicity.
Acculturation data reflected cultural awareness which refers to the individual’s knowledge of cultural traits. Most frequent markers of acculturation are generation, language, history, and observance of national holidays. Data reflect generation, language preference, and preference of holiday celebrations. Table 4.2 summarizes the data reflecting caregiver cultural awareness.

Data on acculturation show that acculturation level for most caregivers was high reflected in generation, preference for English, and celebration of American
Table 4.2
Caregiver Cultural Awareness

<table>
<thead>
<tr>
<th>Subject</th>
<th>Generation</th>
<th>Language Preference</th>
<th>Holiday Celebration Mexican or American</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>1st</td>
<td>Spoken &amp; Written - English</td>
<td>Both Mexican &amp; American</td>
</tr>
<tr>
<td>PS</td>
<td>3rd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>SM</td>
<td>2nd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>MK</td>
<td>3rd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>TW</td>
<td>2nd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>YF</td>
<td>4th</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>GD</td>
<td>4th</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>NB</td>
<td>4th</td>
<td>Spoken &amp; Written - English</td>
<td>Both Mexican &amp; American</td>
</tr>
<tr>
<td>WS</td>
<td>3rd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
<tr>
<td>ZQ</td>
<td>3rd</td>
<td>Spoken &amp; Written - English</td>
<td>American</td>
</tr>
</tbody>
</table>
holidays. Data did not show any observable effect of acculturation level on caregiving in this sample of Mexican American caregivers.

Ethnicity

Ethnic loyalty is the second process of cultural orientation and change among Mexican Americans (Keefe & Padilla, 1997). Ethnic loyalty is the individual’s “preference for one cultural orientation and ethnic group rather than another” (p.46). At the time the research study was explained to subjects, all subjects were questioned regarding all criteria for inclusion. At this time, all subjects declared their ethnicity to be Mexican American. During the interview, they were asked once more to self identify and to identify the elder’s ethnicity. Additional ethnicity data were analysis in two steps. First, caregivers were classified by education level and categorized according to type. Table 4.2 illustrates the assignment of each subject given their formal education level.
Table 4.3

Formal Education and Ethnicity Type

<table>
<thead>
<tr>
<th>Caregiver Formal Education</th>
<th>Ethnicity Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 12 years</td>
<td>CC &amp; GD</td>
</tr>
<tr>
<td>High school</td>
<td>SM</td>
</tr>
<tr>
<td>Technical or vocational</td>
<td>YF</td>
</tr>
<tr>
<td>Some college</td>
<td>NB</td>
</tr>
<tr>
<td>Associate degree</td>
<td>PJ</td>
</tr>
<tr>
<td>Completed college</td>
<td>TW</td>
</tr>
<tr>
<td>Some graduate</td>
<td>WS</td>
</tr>
<tr>
<td>Graduate degree/masters</td>
<td>MK &amp; ZQ</td>
</tr>
</tbody>
</table>
Second, caregivers were categorized by ascribing to subjects certain characteristics of ethnicity type. Table 4.4 is an example of characteristics of one type. Data for all subjects is seen in appendix I.

The typology consists of five types that describe the individual’s attitude toward American culture and people, and their perception of discrimination against people of Mexican descent in the United States. Table 4.5 summarizes results of the number of ethnicity characteristics identified in each subject according to type.

Data from questions regarding ethnicity were organized using characteristics of Keefe and Padilla’s (1987) ethnicity types. Data reflected that the two caregivers, SM and TW, were 2\textsuperscript{nd} generation, Cultural Blends, and differed only in that SM was less educated than TW. Four caregivers, PS, MK, WS, and ZQ were 3\textsuperscript{rd} generation New Americans and only PS lived in the barrio and didn’t understand why others didn’t understand the Mexican religious practice of “posadas” (Advent time preparation for Christmas). WS disclosed (after the taped stopped) that she felt her ethnicity was “diluted” because she had married a non-Hispanic man. She stated she sometimes traveled miles out of her neighborhood to the Mexican side
Table 4.4

Ethnic Characteristics Demonstrated by Caregivers

<table>
<thead>
<tr>
<th>CC</th>
<th>PJ</th>
<th>SM</th>
<th>MK</th>
<th>TW</th>
<th>YF</th>
<th>GD</th>
<th>NB</th>
<th>WS</th>
<th>ZQ</th>
</tr>
</thead>
</table>

**Type I /La Raza**

- Likely to be first generation that arrived in the United States as adults.
- Tend to be lower class,

- Less educated, X X

- Less socio-economically mobile;

- They are likely to live in barrios. X

- Appear to have no doubt when self identifying as “Mexicano”.

- Home may have religious statues and Mexican style pictures of saints.

- Knowledge of Mexican traditions and customs is extensive, especially Mexican national holidays X X

- Relatively little knowledge about U. S. holidays.

- May see dissimilarities in relationships between neighbors, with people living in the United States being more isolated and unfriendly. X
Table 4.5

Ethnicity Type Characteristics

<table>
<thead>
<tr>
<th>Self Identification</th>
<th>Generation</th>
<th>Types according to Generation</th>
<th>Number of Ethnicity Characteristics according to type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I: LaRaza</td>
<td>[2, 2, 4, 0, 0]</td>
</tr>
<tr>
<td>CC</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SM</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>III: Cultural Blends</td>
<td>[0, 1, 4, 2, 3]</td>
</tr>
<tr>
<td>TW</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>III: Cultural Blends</td>
<td>[0, 0, 5, 2, 3]</td>
</tr>
<tr>
<td>PS</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[3, 1, 0, 3, 3]</td>
</tr>
<tr>
<td>MK</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[0, 1, 2, 2, 3]</td>
</tr>
<tr>
<td>WS</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[0, 0, 2, 1, 5]</td>
</tr>
<tr>
<td>ZQ</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[0, 0, 2, 1, 3]</td>
</tr>
<tr>
<td>YF</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[0, 0, 3, 1, 2]</td>
</tr>
<tr>
<td>GD</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[2, 4, 2, 1, 1]</td>
</tr>
<tr>
<td>NB</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>V: New American</td>
<td>[0, 1, 3, 1, 2]</td>
</tr>
</tbody>
</table>
of town just to shop in a certain grocery store. The last three caregivers, YF, GD, and NB were 4\textsuperscript{th} generation, New Americans, and only GD differed due to living in the barrio and being less educated, characteristics of type I and II. Caregiving data were analyzed according to groups of caregivers by generation and ethnicity. No observable differences were noted.

Familism

Familism was defined as feeling close to siblings, celebrating special occasions and holidays together as well as being able to ask for assistance, and being there for others in time of need.

Because caregiving occurred within the context of familism, data reflect statements that described caregivers’ feelings of being close to brothers, sisters, uncles, aunts, cousins and grandparents. There were memories of family celebrations, of always being together, even after siblings got married. One caregiver still lived in the barrio where uncles, aunts and cousins had lived; she remembered having block parties for no special reason, and of experiencing some change due to elders dying. She still enjoyed family celebrations, with nieces and nephews. All caregivers stated family celebrations were common in the past and continued to occur.
PS: [brothers and sisters here all the time?] “Yes... Even, after they got married. ...brother comes at least four times a week...he comes and if my dad needs help with you know gardening and things like that...[family] They still get together and come and go...the whole place was full of cars cause we’d all here, and then ...everybody would just come, and then suddenly it was a potluck. ...who’s party, who’s birthday, nobody’s, just a get together to see grandma...so everybody came to see her.”

MK: “family was always together; even after [brother] got married...we are a very close family unit. Grandchildren very close in an interesting way, we don’t call each other daily, or are in each other’s lives, but all the major holidays all the birthdays, all the people that need help, support, we’re there, ...we’re kind of independent...But...we have a very, very good family relationship, my grand nieces, my nieces and other children we’re really, really close, my mom and dad, my nieces, their grandchildren, granddaughters, were very close to nana[grandmother] and tata[grandfather]...and still are very close.”

ZQ: “my grandmother and I, we had a special bond, she babysat for me when my son was little and she took care of us, my siblings...I had this special bond,...I spent time with her, I’m the one who spent more time with her throughout life.”

TW: “we celebrate birthdays, holidays, mother’s day, father’s day Baptisms, graduations...”

GD: [do you all get together] “All the time, we are close...usually get together...like where my mom is, if she’s here, they [siblings] come here, if she’s at my sister’s, we go there.”

One caregiver, who was an only child, stated that family celebrations were no longer true, that it had ceased when her father and her grandparents had died.

WS: “...celebrate the holidays, my grandparents, family get together, and family coming all those things, graduations...I think once the older people start going, I find it hard for the family, they are kind of the glue, I didn’t come from a typical family of 12, she [mother] had a hysterectomy and that did that.”
Visiting family members on holidays, as well as for coffee on a Sunday was common. Comments of congregating at whose ever house was the biggest, or going to where the elder was on that particular day.

NB: "...celebrations in the family Mexican or American holidays...just about everything,...like on Sundays,...aunts came by ...for coffee...birthdays, we usually have dinners, or Mexican or American holidays we usually have someone there at the house or go to someone else’s, but rarely somewhere else."

ZQ: [family] "We usually gathered at both grandparents. We would go to church where my paternal grandmother lived, and we’d have breakfast with her and then we usually go in the afternoon and see my maternal grandparents...they came to our house, both set of grandparents...for thanksgiving, and Christmas day we’d have dinner with my maternal grandmother." "Mostly family picnics, go with cousins...all family communions, birthdays, and then we on holidays split our time between the two grandparents...[family] still gets together...we go to my sister’s,...on Christmas Eve and Thanksgiving cause she has the most children and she has the most grandchildren so my grandfather...the great grandchildren love him to death, his great, great grandchildren.”

There was feeling of being alone due to lack of family, therefore sparking a need to relocate and be closer to "the family"; of family members being far, but that not making a difference as far as their feelings of closeness was concerned.

YF: "I lived in California, and we came back because of family, family...we didn’t have anybody except for my son in California, and we started realizing we needed the family, and my daughter got transferred...so we made the decision...retired here."

TW: "My daughter and I are very close distance doesn’t make any difference for us."
ZQ: [major force to move back?] “That my entire family was here and that was really the only thing.”

ZQ: “So my older son...family, I see it in him...he moves away,...get jobs,...it never lasts for more than a year, cause he’s pulled back he keeps getting pulled back to the family and he moves because he wants to be close to the family, he needs that family connection, and he knows that no matter what there’s family...friends come and go, but the family’s ...so he knows that he always has that.”

ZQ: [does it take work to maintain that relationship?] “I guess it does, but when you’re close it’s not. You know, I mean my sister would send with my mother her children to my house to visit, I would send my son over here to visit in the summer, and I mean we talked on the phone it’s a natural thing.”

Caregivers who did not live with elders visited elders 2 to 4 times a week. Other elders were visited by non caregiving children and other family members at least once a week and/or calling often, in one case calling every day.

TW: [visit]“Two to three times a week, I talk to them every single day and see them just stop by if they need something or not.”

Familism represented feelings of closeness to siblings and other members of the family. Within this context, families selected, adapted, modified, and interpreted the role for caregivers in this study. The emerged theory of Role Acceptance poses some hypotheses.

Hypotheses

Considering the findings of the grounded theory of Role Acceptance for Mexican American intergenerational caregivers, the following hypotheses are provided:
1. The more positive the early caregiving experiences are, the more positive the primary socialization to the caregiving role is for an individual.

2. The more explicit the messages of role assignment and acceptable family conduct are the more the individual identifies with the caregiving role.

3. The more positive the transition period is the more acceptable the caregiving role assignment is.

4. The lower the level of caregiving intensity, the fewer the lifestyle changes the caregiver has as a result of the caregiving experience.

5. The more individuals the caregiver knows in similar roles, the more positive the caregiver views his/her role.

6. The more positive the historical relationship between elder and caregiver is, the more desire the caregiver has to perform the caregiving role.

7. The stronger the familism is, the less need for peer support.

8. The stronger the familism is, the higher the kin support.

Summary
Chapter four presented a four phase grounded theory of Role Acceptance of intergenerational Mexican American caregivers. The explanation of the grounded theory defined
phases and examples from data were presented. Description of
generational and ethnicity status was provided. Familism
was discussed in context of the caregiving experience. And
finally, hypotheses were proposed.
CHAPTER FIVE
DISCUSSION

The purpose of this exploratory study was to 1) develop an intergenerational caregiving model for Mexican Americans focusing on the temporal axis of caregiving, and 2) describe the influence of culture on this model. Specific research questions were:

1. What are the characteristics of the temporal axis for Mexican American Caregivers?
   a. How do Mexican Americans define caregiving in terms of family structure or generational attitudes (historical time)?
   b. What and how do shared understandings with elders and among family members influence who assumes the caregiver role and when (kin time)?
   c. How does entry into the caregiving role affect the entire family (intergenerational development time)?
   d. How does entry into the caregiving role affect the caregiver’s peer relationships (peer time)?

2. To what extent do cultural values guide the caregiver during the trajectory of the caregiving experience?

3. How is the Mexican American caregiving model influenced by acculturation?
Chapter five is organized in the following manner. First, interpretation of findings are discussed in relation to the research questions. Second, findings and symbolic interactionism are discussed. Third, the contrast case is presented. Fourth, the methodological limitations are discussed. Fifth, future research ideas are presented. Finally, the significance of this study with regard to nursing practice and health care policy is discussed.

Interpretation of Findings
Related to Research Questions

This study explored the relationship between the temporal context and the Mexican American caregiving role. Selected categories of the emerged grounded theory of role acceptance provided the descriptions of the temporal time dimensions. Time dimensions, historical, kin, peer, and intergenerational, influence both the structure and the functioning of the Mexican American caregiving role. Historical time focuses on "demographic" changes in family structure or "generational" attitudes about caregiving; kin time encompasses "shared understandings among family members" regarding who and when certain family members assume the caregiving role; peer time involves the "patterns of temporal synchronicity" in which friends or colleagues of the caregiver engage in caregiving roles in their own families; and intergenerational developmental time relates
to the “timing of entry” into the caregiver role (Burton & Sorenson, 1993, p. 48).

Historical Time

Data from categories Early Age Responsibilities and Past Observed Caregiving of phase one, and Acceptable Family Conduct of phase two provided the definition of historical time as instances in which the caregiver, at an early age, observed or assisted with providing needed assistance to family members. Acceptable Family Conduct provided messages throughout life about what was valued within the family when it came to providing assistance. Some of the structural changes to the family were in terms of incorporating grandma into the caregiver’s household because she needed care, or because grandpa had died and she didn’t want to live alone.

Kin Time

Data from categories Past Kin Help of phase one, and Current Kin Help of phase four provided the definition for kin time as instances that reflected collective labor, in past and present caregiving experiences. This collective labor was expected of family members in order to endure time of need. Receiving assistance from other family members provided a feeling of solidarity in which everyone did his/her part. There were also statements that siblings did
not always provide needed assistance. There was no observable reason for this difference.

Peer Time

Data from the category Timing of the Role Entry of phase three provided the definition of peer time as the time of role acquisition and its synchronization with peers. The caregiver either identified with others who had similar role responsibilities or felt that others could understand what they were going through. One caregiver who did not know anyone in a similar role felt alone with no one to understand. This could be a result of having recently moved to the area and not being able to make friends since she her elder required constant vigilance.

Intergenerational Time

Data from the category Role Assignment provided the definition of intergenerational time as instances where the caregiver had been given explicit or implicit messages of why the caregiving role needed to be executed by them. Acceptance of these messages, allowed the caregiver to accept their role as something that was expected and therefore normal in their life trajectory.

The time dimensions were not readily apparent using grounded theory methodology. Rather, it was necessary to do a content analysis to attempt a definition of the time dimensions in the temporal axis. Although the time
dimensions provided a useful framework for guiding interview questions, solid definitions were not achieved due to the integral nature of the time dimensions.

Cultural Values and Caregiving

The cultural value of familism was noted extensively throughout the categories. Caregiving occurred within the context of familism, reflected statements that described caregivers’ feelings of being close to brothers, sisters, uncles, aunts, cousins and grandparents. Caregivers had memories of family celebrations, in the past as well as at the present time, of always being together, even after siblings got married. Caregivers who did not live with elders visited elders 2 to 4 times a week. Other elders were visited by non-caregiving children and other family members at least once a week and/or calling often, in one case calling every day. Familism is often manifested by close relationships and involvement with the members of the family (Marin & Marin, 1991). Data also reflected that caregivers felt that the elders should be respected and that they were very private individuals, therefore they needed to maintain their dignity.

Acculturation and Ethnicity and the Caregiving Model
Acculturation data reflected cultural awareness which referred to the individual’s knowledge of cultural traits while ethnic loyalty was the caregivers’ preference for one cultural orientation and ethnic group rather than another (Keefe & Padilla, 1987). Keefe and Padilla’s (1987) typology reflected consistent categorization using caregivers’ generation and ethnicity characteristics when grouped by generation. There were three caregivers who demonstrated characteristics outside their classification. These exceptions were residence in the barrio and with low level of education. Keefe and Padilla (1987) state that “residence in a barrio is the primary factor related to ethnic identification” (p. 9). This was not the case with the caregiver in this sample who lived in the barrio, she self identified as American. Keefe and Padilla go on to say that caution should be taken against making any broad generalizations about Mexican Americans without analysis across generations and socioeconomic levels. There is no influence of acculturation seen in this caregiving model.

Discussions of Findings

This exploratory study of intergenerational caregiving for Mexican Americans focused on the temporal dimensions of time on the caregiver role. The grounded theory brings to light the “social and psychological dimensions of temporal context that influence both the role perceptions and
performances of individuals and families who are principally responsible for providing care to elderly dependents” (Burton & Sorensen, 1993, p.48).

Specific dimensions of time within the temporal axis of the caregiving paradigm (Figure 1.1) which are historical time, kin time, peer time, intergenerational time, and social time, reflect the social construction and meaning of role perceptions and performances of caregivers. Exploring the time dimensions of this axis addresses the question of the development and the timing (when?) of the caregiving role. Symbolic interactionism proposes that an “agreement exists when the cognitive processes of one person are not in gross conflict with the expressive processes of the other person” (McCall & Simmons, 1978, p. 139). This theoretical perspective provides the framework to discuss the emergence and acceptance of the caregiving role in this study.

In order to understand individuals who accept the caregiving role, we must consider the influences of their relevant life histories. According to McCall and Simmons (1978), “interactions are shaped by the past and influenced by the expectations of the future.” The interaction is “shared by participants and by shadows from the past, which channel the course of today’s whos, whats, whens, and wheres.” Interactions are not isolated occurrences, but “sequences in the entire life histories of individuals” (p. 200).
In this study, the categories that emerged from the data represent the process of role emergence, role evolution, and role identity. Figure 5.1 illustrates the relationship between the phases of the grounded theory of role acceptance and the temporal axis of the caregiving paradigm. Phase one Introduction and the first two categories of phase two, Role Assignment and Acceptable Family Conduct represent Role Emergence; the third category of phase two, Transition, represents Role Evolution; and phase three, Role Imprint represents Role Identity. The movement between phases is depicted in linear fashion, but in actuality it is a dynamic process with one stage drawing upon the others continuously.

Role Emergence

According to McCall and Simmons (1978), there are two main factors in the early history of the individual that are behind the eventual emergence of a role-identity. First is that from the moment of birth, certain social roles are ascribed to the individual by parents and others. The second is that the role emergence consists of certain aspects of the primary socialization and gradual acquisition of the basic interactive skills; which consist
Figure 5.1: Process of Role Acceptance and its Relationship to the Temporal Axis
of “(1) the emerging sense of self and other, (2) role learning and anticipatory socialization, and (3) development of expressive skills” (p. 203). Phase one and categories one and two of phase two represent role emergence. In phase one, caregivers and siblings are introduced to the role by helping take care of grandparents, or by being required to help mother in situations of absent fathers. In the categories of role assignment and acceptable family conduct of phase two, caregivers are aware of their position in the family structure such as the oldest, youngest, or middle child. They are also being socialized into what families do and don’t do when it comes to rendering care to other family members. All caregivers in this study expressed pride in coming from families that had “always taken care of the elderly”, of what constituted being good children. This is consistent with Mexican American caregivers studied by Jolicoeur and Madden (2002) whose sample considered caregiving to be an “integral part of being a good daughter” (p. 116). In other research, fulfillment of role obligations was identified as “overwhelmingly the most rewarding aspect of caregiving” (p. 115), and attributed with providing “strength” and limiting the “negative effects” of the caregiving situation (John, Resendiz & De Vargas, 1997, p. 153).

Role Evolution
In role evolution, “the role-learner has learned some of the rudiments of a particular role” and he typically “tries it on for size” (McCall & Simmons, 1978, p. 212). At this transition time, the elders may not be in need of physical care, but opts to live with the caregivers due to the absence of a spouse. In one instance the caregiver lived some 800 plus miles away, and the elder would go and spend months at a time visiting the caregiver and her family. This occurred several times before she finally moved in with the caregiver. Another elder was living with the caregiver, helping out with the housework and cooking, in return for assistance with transportation and translation especially when visiting physicians. The choice to have the elder live with the caregiver may have been the caregiver’s or the elder’s decision. In this study, two elders did not live with the caregiver, but in both cases the caregiver visited the elder 2-4 times a week. These findings of visiting and cohabitation, are consistent with those found by Dietz (1995) who reported that Mexican American elderly had frequent contact with their children; 80% of their respondents lived with or near an adult child; and most elderly who were not living with their children had daily or weekly visits. Phillips (2002) proposed that Mexican American children may assume the caregiving role earlier than non-Hispanic whites, when their elders are less functionally impaired; and that daughters assuming
caregiving roles earlier may be a function of Mexican American children’s propensity to protect their aging mothers. Phillips (2000) also reported that “Mexican American adult children provided care whether or not a spouse was available” (p.309). Evolution of the role calls for the learner, who usually knows only the most central of the requisite role behaviors, to slowly and sometimes painfully become aware of the less appealing activities of the role (McCall & Simmons, 1978). So too, as the caregiver begins to take on responsibilities in a variety of ways, and assists the elder, she becomes aware of the increasing responsibility and the reality of the elder’s health status severity increasing.
Role Identity

“Identification of persons and of other ‘things’ is the key to symbolic interaction; once things are identified and their meanings for us established, we can proceed with our individual strivings, but not before” (McCall & Simmons, 1978, p. 62). The caregiver has now systematically placed all caregiving messages from the past, coupled by the present circumstances related to the elder, into their perspective categories. These messages are often taken for granted and are considered self-evident, and whether or not these messages are reasonable is never entertained. "Indeed, as the individual grows up in that social grouping, he internalizes and acts in terms of these conceptions of what each life phase is, so that he makes the conceptions ‘come true’ by dutifully fulfilling them" (P.220).

As individuals acquire new roles, there are important audiences from which to gain approval and role-support. One of these audiences typically includes the peer group. The majority of caregivers in this study noted that friends and family were also in the same caregiving role. They felt that they could “commiserate”, and “share similar experiences” with them; that others providing care knew and understood what it was like to be a caregiver. Their feelings were positive and provided support for their position. This is consistent with findings of group solidarity and positive feelings toward the caregiving role
when individuals have peers who are also caregivers. These findings were reported by Burton and Sorensen (1993) from four ethnographic studies of multigenerational African-American families. Pillemer, Suitor and Wethington (2003) reported the contrary; that “although caregivers enjoy interaction with individuals who share their caregiving status, these ‘grafted’ relationships are not sufficient to have effects on well-being” (p. 23).

In addition to peer support, self-support, commitment and investment allow the individual to influence the molding of the role (McCall & Simmons, 1978). Reciprocity or giveback at this stage asserts the caregivers’ commitment of familial responsibility and the importance of the relationship with the elder. Internal factors must correspond with external factors; if they don’t the individual is “likely to feel discontented with his lot and will be motivated to bring them into closer alignment” (p.218).

There is compromise on the definition of the role and character of the social identities between the caregiver and the elder. There is an agreement of which social position each person belongs to, for purposes of the present encounter. This agreement is essentially “a working agreement” which will form the basis on which to negotiate the interactive roles. According to McCall and Simmons (1978) “a working agreement can be said to exist when the
cognitive processes of one person, with respect to social identities, are not in gross conflict with the expressive processes of the other person” (p.199). Regardless of whether these agreements are stable or unstable, these interpersonal relationships turn to the main business of the encounter, caregiving, entering into a negotiation of interactive roles.

Role Interaction

In role interaction, the task focus can assume endless forms, in phase four, Providing/Projecting Care. Caregivers actually engaged in providing care to the elder have a working agreement with the elder. Occasionally this agreement can be called into question when one person’s actions differ from the other’s expectations. This will suspend task performance until a renegotiated working agreement is established (McCall & Simmons, 1978). Caregivers in this phase are facing the reality of their role. There are family activities that require adjustment. Their social lives are also impacted, especially caregivers who are accustomed to socializing outside the family. This impact is not as significant for caregivers who mainly socialize with other family members. Caregivers have working agreements with other members of the family, for example siblings; therefore a caregiver can experience multiple disruptions in working agreements from different
sources. This is evident when the caregiver expects assistance from a sibling and for some reason the sibling does not comply.

Summary

The caregiver’s self-conceptions and behavior are not restricted to the phase of life she happens to find herself in. There are lessons that have been learned from messages and images from all phases; she remembers and she looks ahead, so her identities and interactions are both representations of preceding phases and anticipations of subsequent ones. “Those phases that are most highly valued in the culture cast a shadow over the occupants of all other phases, and, to the extent that they are capable, persons tend to adopt and carry out modes that are most characteristic of the favored phases” (McCall & Simmons, 1978, p. 222).

The Contrast Case

The contrast case was that of a daughter-in-law, first generation Mexican, caring for her mother-in-law, first generation Mexican, in the caregiver’s home. This caregiver experienced early caregiving when her mother had taken care of an aunt with cancer. She had assisted other family members with translation when visiting physicians. She felt that her uncles had helped in the past when needed. This
caregiver did not remember ever being designated to provide care. She stated that although her grandmother was almost 80 years old, she was still very independent, lived alone in Mexico and her uncles only watched over her. This caregiver also considered her mother to be self sufficient and not needing any help. The caregiver had provided some assistance to the elder (her mother-in-law), prior to the elder moving in with the caregiver, whenever the elder visited her home for short periods of time. The caregiver stated she had been selected to care for this elder because “she was the dumb one”, explaining that her sisters-in-law just did not want to do it. The caregiver believed that maybe her husband, being the oldest of four males, may have been given this charge, but did not know that for sure. The caregiver and her husband had planned for her to return to work at this time when their children were all in school, and she clearly blamed her husband for not standing up to the rest of his family resulting in the change of plans. This caregiver felt that her children were suffering because she did not have enough time for them, and she had no time to visit with friends. She was resentful that her mother-in-law had decided to bring her youngest daughter and come live with the caregiver and her family. Even though the house was large, this brought the total of people living in the house to nine. The caregiver was reluctant to place
the elder in a nursing home, even if she had the resources, because the elder was mentally alert.

Although this caregiver had experiences in phase one, Introduction/Early Caregiving Experiences and phase four, Providing/Projecting Care of the model, she clearly had not experienced phase two, Role Reconciliation or phase three Role Imprint.

Methodological Limitations and Strengths

Some areas within this model need to be developed.

1. Data are needed from elders and children of next generation, this would strengthen understanding about intergenerational messages regarding caregiving attitudes.

2. Messages of Role Assignment would be strengthened by obtaining data from siblings of caregivers.

3. Data about the past and present relationship between elder and caregiver would add to the context in which the caregiving role is accepted and executed.

4. More data are needed from first and second generation caregivers to test theory.

5. Because this study consisted of only caregivers of elders with consanguinal ties, it reveals little about caregiving involving other types of family relationships. The contrast case suggests the process may be different for other groups.
The contrast case, later determined, was the first interview. And because this researcher was optimistically looking for common themes in the first and second analysis of interviews one and two, the inconsistency was not fully anticipated and proved to be somewhat unbalancing. Common themes found in interviews two and three restored some of the confidence in this researcher.

There was no problem obtaining a sample. Ample time was spent in orienting community outreach individuals regarding the process, criteria and script, for recruiting possible subjects for inclusion to the study. The researcher was acquainted with community outreach individuals; therefore there was an established relationship that augmented the process.

Theory validation checks with volunteers were gratifying as their response was very positive, especially since one was a first generation Mexican and the other a third generation Mexican American. This provided further assurance of the transferability of the theory. The first journal entry, prior to beginning interviews, was a detailed journal entry of the researchers’ own values and constructions. This proved to be especially beneficial in that, although a good part of the family values and acceptable family conduct are consistent with the data, there was no experience with caregiving of elderly in the past, there were no big family celebrations, there was no
messages of who was to be assigned the role, and the elder at this present time is 92 years old, lives alone, and has just begun to lose her independence. This researcher’s construction was more consistent with the contrast case in some areas.

Categories were for the most part well saturated. Social Impact and Current Kin help lacked saturation, but were balanced with the overwhelming representation of familism. These two were synonymous for most caregivers. Findings from the analysis of the acculturation and ethnicity data presented some inconsistent results. This presented the question of whether the typology used reflected only individuals in Southern California where the original studies had occurred and whether this could be transferred to individuals in the Southwest part of Arizona. It was not until the data were organized in groups determined by the caregivers’ generation that ethnicity characteristics begun to show consistency with generational status. There’s a question of whether acculturation and ethnicity should have been measured quantitatively instead of qualitatively.

The lack of observable acculturation and ethnicity influences on caregiving in this model may be due to a homogeneous sample. Another possibility is what Johnston (1963) proposed as two components to assimilation. These are external and subjective assimilation. In this case,
external assimilation existed when caregivers accepted in an outward manner certain aspects of the culture such as language and the celebration of American holidays. Subjective assimilation might explain an individual psychological selection of how caregivers selected certain ethnicity characteristics to identify with and not others. Johnson (1963) further states that external assimilation can exist without subjective assimilation, but not vice versa. In contrast, acculturation is an acceptance that does not require a change of values.

Future Research

In order to place this theory in the context of the past, the present, and the future generations of Mexican Americans, it was necessary to conceptualize how the role acceptance process might exist in relation to three generations. Figure 5.2 shows this conceptualization. This model is composed of four levels, the first generation, the second generation, level A, the second generation level B, and the third generation.

First Generation Level

The first generation consists of elders. This level is proposed to contain three phases from the emerged theory of role acceptance: phase four Providing/Projecting Care; phase five, End of Caregiving; and phase six, Receiving
Care. Phase four in this generation reflects caregiving that the elders performed in the past which served as the introduction of caregiving to the present generation, in this case the caregivers in this study. Phase five, is assumed to have occurred since the elder’s caregiving experience ended. Phase six, places the elder as the receiver of care.

Second Generation Level

This level is comprised of two sublevels, A and B. Level A represents caregivers who obtained their introduction to caregiving from early responsibilities in their lives that required assistance and support to a parent in the absence of one of the parents.

Level B represents six phases, the first four which emerged from this data and the assumption of phase five, End of Caregiving that will eventually occur; and phase six, which represents the time when these caregivers will need to become the care receivers.

Third Generation Level

This level is comprised of the first four phases, and proposed to possibly exist in this generation. Phase two of the second generation serves as the introduction of the caregiving role for the third generation. Phase three and four of the second generation is proposed to influence phase
two, three and four of the third generation. All shaded phases were not explored in this study, and all possible relationships between phases have not been fully explored.

Given the emerged model from this study, as well as possible relationships of this model to other generations, future research questions might consist of:

Does the present model apply to Mexican American family caregivers other than those with consanguinal ties?

How consistent are the messages about caregiving between the first, second, and third generations?

What effect do acculturation, ethnicity, and familism continue to have on the caregiving model?

Significance

This investigation of Mexican-American caregivers was designed to document and understand how caregiving was defined; who made the decisions; when these decisions were made; and how they were carried out, utilizing a temporal perspective. This study was able to document a portion of the meaning individuals ascribe to the definition of what it means to be a caregiver within the context of the Mexican American culture. This study adds to the limited knowledge of caregivers from the temporal aspect. According to Burton and Sorensen (1993): “examination of the relationship between temporal context and the caregiving role has not been previously addressed in the literature” (p.47). This
study also adds to the limited literature in Mexican American caregiving research. This type of research is needed in order to design nursing interventions to support caregivers based on understanding the issues; to create and design systems that address the varying and ever changing needs of informal caregivers; and to assist in formulation of policy that supports Mexican American caregivers.

The ultimate aim is to provide information that allows nurses to practice in a manner sensitive to the needs of individuals and their families. Nursing is mandated to continue to grow in scope of practice as healthcare environments increase in diversity, care must respect the differences and similarities of cultural values, beliefs, and life styles (Leininger, 1997). Use of theories such as this promote and enhance critical thinking and understanding how culture influences individual views of what it is to be a family caregiver. This intergenerational caregiving model can assist nursing in the delivery of culturally competent nursing care.
### APPENDIX A

**LITERATURE SEARCH CHART**

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## APPENDIX B

### LITERATURE REVIEW CHART

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<td>Contributing factors to feelings of burden with senile dementia. N=29</td>
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<td>Phillips, Torres de Ardon, Komnenich, Killeen, &amp; Rusinak, 2000</td>
<td>Compares Mexican American caregivers to NonHispanic White caregivers and describes differences in the caregiving structure and caregiving experience. MA (n=196); NHW (n=165)</td>
<td>Experimental</td>
<td>Positive</td>
<td>Negative</td>
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<td>Deimling, Smerglia, &amp; Schaefer, 2001</td>
<td>Examined caregiver depression in context of traditional care-related primary stressors</td>
<td>Cross-sectional</td>
<td>Positive</td>
<td>Negative</td>
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<td>Gaugler, Pearlin, Leitsch &amp; Davey, 2001</td>
<td>Factors that predict problems when institutionalizing and elderly relative. N=185</td>
<td>Longitudinal</td>
<td>Positive</td>
<td>Negative</td>
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<td>Kosloski, Montgomery &amp; Youngbauer, 2001</td>
<td>Identify factors of respite users from non users. N=458</td>
<td>Case-control</td>
<td>Positive</td>
<td>Non-aligned</td>
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<td>Montgomery &amp; Williams, 2001</td>
<td>Addresses different sources for the inequality of costs for care of those afflicted with Alzheimer's disease</td>
<td>Case-control</td>
<td>Positive</td>
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<tr>
<td>Brereton &amp; Nolan, 2002</td>
<td>Investigates new caregivers of stroke survivors for uncertainty and lack of confidence. N=37</td>
<td>☑️</td>
<td>☑️</td>
<td>Non-aligned</td>
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<tr>
<td>Grant, Adler, Patterson, Dimsdale, Ziegler, &amp; Irwin, 2002</td>
<td>Examined the extent of chronic stress of Alzheimer’s disease caregivers and alleviation due to placement or death. N=119</td>
<td>☑️</td>
<td>☑️</td>
<td>Negative</td>
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<tr>
<td>Jolicoeur, &amp; Madden, 2002</td>
<td>Explores dynamics of informal care of the elderly in Mexican American families. Examines burden of caregiving. N=39</td>
<td>☑️</td>
<td>☑️</td>
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APPENDIX C

GENERAL DEMOGRAPHIC INFORMATION FORM

For Research Study
Temporal Aspects of Mexican American Intergenerational Caregiving

Información Demográfica
Para el Estudio en la Investigación

Aspectos Temporales de Cuidado Intergeneracional
de Mexicano-Americanos

Directions: Please answer the following questions. The information you provide will only be used for this study and will not be seen by anyone else.

Direcciones: Por favor conteste las siguientes preguntas. La información que usted proporciona sólo será usada para este estudio y no la verá nadie más.

1. Caregiver’s Gender  M=1  F=2
1. Género del Cuidador  M=1  F=2

2. Elder’s Gender  M=1  F=2
2. Género del Mayor  M=1  F=2

3. Age of Caregiver ___________
3. Edad del Cuidador ___________

4. Age of Elder ____________
4. Edad del Mayor ____________

5. How long have you been a caregiver for the elder?

Note: A caregiver is a person who regularly provides (in months) at least one intermittent service to the elder, without being paid.

5. ¿Cuánto tiempo tiene usted cuidando a su mayor?

Nota: Un cuidador es una persona que proporciona a lo (en meses) menos un servicio regularmente al mayor sin pago.

6. Where does the elder live?
6. ¿Dónde vive su persona mayor?
   ____con usted en su casa/apartamento =1
   ____con usted en la casa/apartamento de su persona mayor =2
   ____con usted en una casa/apartamento propio de los dos =3
   ____solo en la casa/apartamento del mayor =4
   ____con _________en casa/apartamento propio que el mayor tiene/renta =5
   ____con _________en casa/apartamento propio que alguien mas tiene/renta =6
   ____otra (con detalle) ___________________=7

7. How many people, including the elder, live in the house where the elder lives?____

7. ¿Cuántas personas, incluyendo al mayor, viven en la casa donde vive el mayor?____

8. Your relationship with the elder?

   ____daughter =01  ____spouse = 09
   ____son =02       ____aunt =10
   ____daughter-in-law =03  ____uncle =11
   ____son-in-law=04  ____niece =12
   ____granddaughter =05  ____nephew =13
   ____grandson =06  ____sister =14
   ____cousin (m) =07  ____brother =15
   ____cousin (f) =08  ____other = 16
   specify__________

8. ¿Su relación con el mayor?

   ____hija =01     ____pareja = 09
   ____hijo =02     ____tía =10
   ____nuera =03    ____tío =11
   ____nuero =04    ____sobrina =12
   ____nieta =05    ____sobrino =13
   ____nieto =06    ____hermana =14
   ____primo (m)=07  ____hermano =15
   ____prima (f) =08  ____otro = 16
   detalle__________
9. Caregiver’s religious preferences
____ Roman Catholic=01  ____ Episcopal=06  ____ Church of God=11
____ Jewish=02  ____ Lutheran=07  ____ Mormon=12
____ Baptist=03  ____ Christian=08  ____ (LDS)
____ Methodist=04  ____ Protestant=09  ____ Unitarian=13
____ Presbyterian=05  ____ Jehovah Witness=10  ____ Assemblies=14
____ none=15  ____ other=16

9. Preferencias religiosas del cuidador
____ Catolico=01  ____ Episcopal=06  ____ Iglesia de Dios=11
____ Judio=02  ____ Luterano=07  ____ Mormón=12
____ Bautista=03  ____ Cristiano=08  ____ (LDS)
____ Metodista=04  ____ Protestante=09  ____ Unitario=13
____ Presbiteriano=05  ____ Testigo/de/Jehová=10  ____ Asambleas=14
____ ninguna=15  ____ otra=16

10. Elder’s religious preferences
____ Roman Catholic=01  ____ Episcopal=06  ____ Church of God=11
____ Jewish=02  ____ Lutheran=07  ____ Mormon=12
____ Baptist=03  ____ Christian=08  ____ (LDS)
____ Methodist=04  ____ Protestant=09  ____ Unitarian=13
____ Presbyterian=05  ____ Jehovah Witness=10  ____ Assemblies=14
____ none=15  ____ other=16

10. Preferencias religiosas del mayor
____ Catolico=01  ____ Episcopal=06  ____ Iglesia de Dios=11
____ Judio=02  ____ Luterano=07  ____ Mormón=12
____ Bautista=03  ____ Cristiano=08  ____ (LDS)
____ Metodista=04  ____ Protestante=09  ____ Unitario=13
____ Presbiteriano=05  ____ Testigo/de/Jehová=10  ____ Asambleas=14
____ ninguna=15  ____ otra=16

11. What is the approximate caregiver’s household income per year? (Check one)
____ Less than $10,000=01  ____ $10 to $19,999=05
____ $20 to $29,999=02  ____ $30 to $39,999=06
____ $40 to $49,999=03  ____ $50 to $59,999=07
____ $60 to $69,999=04  ____ over $70,000=08

11. ¿Aproximadamente, cuál es el ingreso por año de la casa del cuidador? (Marque uno)
____ Menos de $10,000=01  ____ $10 a $19,999=05
____ $20 a $29,999=02  ____ $30 a $39,999=06
____ $40 a $49,999=03  ____ $50 a $59,999=07
____ $60 a $69,999=04  ____ más de $70,000=08

12. What is the caregiver’s level of formal education? (Check one)
____ Less than 12 years=01  ____ High School=04
____ Some college=02  ____ Technical or vocational
12. ¿Cuál es el nivel de educación formal del cuidador? (Marque uno)
   _____Menos de 12 años=01   _____Escuela secundaria =04
   _____Alguna universidad =02 _____Entrenamiento Técnico o Profesional =05
   _____Universidad completado=03 _____Educación Graduada=06

13. What is the elder’s level of formal education? (Check one)
   _____Less than 12 years=01   _____High School=04
   _____Some collage=02   _____Technical or vocational training=05
   _____Completed college degree=03 _____Graduate education=06

13. ¿Cuál es el nivel de educación formal del mayor? (Marque uno)
   _____Menos de 12 años=01   _____Escuela secundaria =04
   _____Alguna universidad =02 _____Entrenamiento Técnico o Profesional =05
   _____Universidad completado=03 _____Educación Graduada=06

   _____No se sabe =07
Appendix D

Human Subject Approval Letter
APPENDIX E

RECRUITMENT SCRIPT

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Sample Script for Community Outreach Individual to Use For Research Study Temporal Aspects of Mexican American Intergenerational Caregiving

*(Community outreach individual will be asked to approach Mexicans, Mexican-Americans, or Chicano individuals)*

Hello, my name is _____. I want to ask you if you are currently providing care for a husband, wife, mother, father, or any other member of your family.

(If answer is yes) Would you be willing to talk to a nurse who is doing a research study that wants to know about how caregiving happens in Mexican-American homes; a study that want to know how families plan and decide issues related to caregiving; and a study that also wants to know how taking care of an elderly family member has affected the entire family.

Would you be willing for me to give her your name and phone number?  
Yes  No

The nurse will call and visit you to explain the study. This way you can decide if you want to participate or not.

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<th>Signature of Potential Subject</th>
<th>Date</th>
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</table>

Phone Number: ________  Address: _________________
Sample Script in Spanish for Community Outreach Individual to Use For Research Study
Temporal Aspects of Mexican American Intergenerational Caregiving

(El individuo de la comunidad se le pedirá que se acerque a mexicanos, mexicano-americanos, o chicanos)

Hola, mi nombre es ___. Yo quiero preguntarle si usted está de cuidador/a a un marido, esposa, madre, padre, o cualquier otro miembro de su familia.

(Si la respuesta es sí) Estaré usted dispuesta de hablar con una enfermera que está haciendo un estudio/investigación sobre cuidado que se da en casas mexicano-americanas; un estudio que quiere saber cómo las familias planean y deciden problemas relacionados a este cuidado; y un estudio que también quiere saber cómo el cuidado de un mayor miembro familiar ha afectado a la familia.

¿Estaría usted dispuesta de darme su nombre y número de teléfono?  
Sí                                  No

La enfermera le llamará y lo/la visitará para explicar el estudio. En esta manera usted puede decidir si quiere participar o no.

Firma de Participante Potencial  
Fecha

Número de teléfono:________________
Dirección:________________________
APPENDIX F

SUBJECT'S CONSENT FORM

Temporal Aspects of Mexican American Intergenerational Caregiving

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE

I am invited to participate voluntarily in the above-titled research project. The purpose of this project is to (1) describe my world as a Mexican American caregiver (2) clarify the processes and issues involved in the formulation of plans and decisions related to my caregiving experiences; and (3) develop an intergenerational caregiving model for Mexican Americans focusing on family structure, shared understandings, and the timing of entry into the caregiving role.

SELECTION CRITERIA

I am invited to participate because I am over 21 years of age; am related to a community dwelling elder through blood relationship or acquired kinship ties; provide at least one intermittent service to the elderly person, without being paid; live within a 50-mile radius of the elderly individual; self identify as Mexican, Mexican-American or Chicano; and am willing to participate. Not more than 16 subjects will be enrolled in this study.

PROCEDURE(S)

If I agree to participate, I will be asked to consent to the following: An interview at a time and location of my choice, for approximately 1-2 hours. I understand the interview will be audiotaped. I will be asked questions about my family history and how care is provided to my family member.

RISKS

There is no risk to me. I can stop at any time.
BENEFITS

There are no benefits associated with my participation in this study. The information I provide may in the future assist health care professional to understand caregiving within the Mexican American culture.

CONFIDENTIALITY

All information associated with the study will be held in confidence and only Socorro Escandón Dominguez and her dissertation advisor will have access to the information. I will be assigned a number, and that number will be on all documents, and transcription from audiotape rather than my name. Only the principle investigator, Socorro Escandón Dominguez will know my identity.

PARTICIPATION COSTS AND SUBJECT COMPENSATION

There will be no cost for me to participate in this study with the exception of time given for the interview of 1 to 2 hours.

CONTACTS

I can obtain further information from the principal investigator Socorro Escandón Dominguez RN, PhD candidate, at (520) 624-4654. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at (520) 626-6721.
AUTHORIZATION

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I MAY ASK QUESTIONS AT ANY TIME AND I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, SOCORRO ESCANDON DOMINGUEZ RN, PHD. CANDIDATE OR AUTHORIZED REPRESENTATIVE OF THE COLLEGE OF NURSING. I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

Subject's Signature       Date

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

Signature of Investigator       Date

1/2000
APPENDIX G

SPANISH CONSENT FORM

FORMA de CONSENTIMIENTO
De Investigacion

Temporal Aspects of Mexican American Intergenerational Caregiving
Aspectos Temporales de Cuidado Intergeneracional Mexicano-Americano

SE ME HA PEDIDO QUE LEA EL MATERIAL SIGUIENTE CON EL PROPOSITO DE ASEGURAR UN COMPLETO CONOCIMIENTO SOBRE LA NATURALEZA DE ESTE ESTUDIO DE INVESTIGACIÓN Y COMO PARTICIPAR EN EL MISMO SI ASÍ LO DECIDERA. SEGÚN REGLAMENTOS FEDERALES SE DEBE PRESENTAR UN CONSENTIMIENTO POR ESCRITO INDICANDO QUE DESPUÉS DE OBTENER LA PARTICIPACIÓN DE ESTE ESTUDIO, LA PERSONA FIRMANTE HA TOMADO UNA DECISIÓN LIBRE DE PARTICIPAR O DE NEGARSE A HACERLO.

PROPOSITO

Yo estoy invitádo a participar voluntariamente en el proyecto sobre-titulado de investigación. El propósito de este proyecto es (1) describir mi mundo de ser cuidador Mexicano Americano (2) clarificar los procesos y problemas involucrados en la formulación de planes y decisiones relacionada a mis experiencias del cuidado; y (3) desarrollar un modelo de cuidado intergeneracional de Mexicano Americanos con enfoque en estructura de la familia, comprensiones compartidas, y la entrada al papel de cuidador.

CRITERIO de la SELECCION

Yo estoy invitádo a participar porque yo tengo más de 21 años de edad; estoy relacionado/a a través de lazos consanguíneo o parentesco adquiridos; a una persona mayor de edad en la comunidad que yo le proporciono por lo menos un servicio personal a una persona mayor, sin pago; vivo dentro de un radio de 50-millas del mayor; me identifico como Mexicano, Mexicano-Americano o Chicano; y estoy dispuesto a participar. No más de 16 personas se enlistaran en este estudio.
PROCEDIMIENTOS

Si yo estoy de acuerdo en participar, me pedirán que consienta a lo siguiente: Una entrevista a un tiempo y situación de mi opción, durante aproximadamente 1-2 horas. Yo entiendo que la entrevista será audiotaped. Se me preguntara preguntas de mi historia familiar y cómo se proporciona el cuidado a mi miembro familiar.

RIESGOS

No hay ningún riesgo para mí. Yo puedo parar en cualquier momento.

BENEFICIOS

No hay ningún beneficio asociado con mi participación en este estudio. La información que yo proporciono puede en el futuro ayudar al los profesionales del cuidado de salud entender cuidado dentro de la cultura Mexicana Americana.

CONFIDENCIALIDAD

Se mantendrá toda la información asociada con el estudio en confianza y sólo Socorro Escandón Dominguez y su consejero de la disertación tendrá acceso a la información. Se me asignara un número, y ese número estará en todos los documentos, y transcripción del audiotape en lugar de mi nombre. Sólo el investigador principio, Socorro Escandón Dominguez sabrá mi identidad.

COSTOS DE PARTICIPACION Y COMPENSACION DEL PARTICIPANTE

No habrá ningún costo para mí si participo en este estudio con la excepción de tiempo dado para la entrevista de 1 a 2 horas.

CONTACTOS

Yo puedo obtener información extensa del investigador principal Socorro Escandón Dominguez RN, candidato de PhD, a (520) 624-4654. Si yo tengo preguntas que involucran mis derechos como asunto de la investigación, yo puedo llamar la oficina de Comité de Asuntos Humanos a (520) 626-6721.

AUTORIZACION

ANTES DE FIRMAR ESTA FORMA DANDO MI CONSENTIMIENTO, LOS MÉTODOS, MOLESTIAS, RIESGOS, Y BENEFICIOS SE ME HAN EXPLICADO Y MIS PREGUNTAS HAN SIDO CONTESTADAS. YO PUEDO HACER PREGUNTAS EN CUALQUIER MOMENTO Y SOY LIBRE DE RETIRAR
ME DEL PROYECTO EN CUALQUIER MOMENTO SIN CAUSAR SENTIMIENTOS MALOS. MI PARTICIPACIÓN EN ESTE PROYECTO PUEDE SER ACABADA POR EL INVESTIGADOR POR RAZONES QUE SE EXPLICARIAN. SI NUEVA INFORMACIÓN SE DESARROLLA DURANTE EL CURSO DE ESTE ESTUDIO QUE PUEDE AFECTAR MI BUENA GANA DE CONTINUAR EN ESTE PROYECTO DE LA INVESTIGACIÓN SE ME DARÁ CUANDO SEA DISPONIBLE. ESTA FORMA DE CONSENTIMIENTO SE ARCHIVARA EN UNA AREA DESIGNADA POR EL COMITÉ DE LOS ASUNTOS HUMANO CON ACCESO RESTRINGIDO AL INVESTIGADOR PRINCIPAL, SOCORRO ESCANDÓN DOMÍNGUEZ RN, PH.D. CANDIDATO O EL REPRESENTANTE DEL COLEGIO DE ENFERMERÍA. YO NO DEJO NINGUNO DE MIS DERECHOS LEGALES FIRmando ESTA FORMA. SE ME DARÁ UNA COPIA DE ESTA FORMA DE CONSENTIMIENTO FIRMAD POR MI.

Firma del participante ______________________ Fecha ______________________

DECLARACION JURADA de INVESTIGADOR

Yo he explicado cuidadosamente al participante el proyecto anterior. Yo certifico mejor de mi conocimiento la persona que está firmando esta forma de consentimiento entiende la naturaleza, demandas, beneficios, y riesgos involucradas en participación de el/ella claramente y la firma del el/ella es legalmente válida. Un problema médico o idioma o la barrera educativa no ha evitado esta comprensión.

Firma del Investigador ______________________ Fecha ______________________
1/2000
APPENDIX H
INTERVIEW QUESTION GUIDE

Questions for Research Study
Temporal Aspects of Mexican American Intergenerational Caregiving

**Historical time**
Changing demography of family Person’s cohort—as to generation
1. Tell me about your parents
2. Tell me about your family
3. Tell me about other family members who have been caregivers

**Kin Time**
Family obligations defined by economic, social, physical, and psychological family needs.
1. When did you decide to become the caregiver?
2. If you had all the money (resources) necessary, how would you change the situation of caring for your ______?
3. Would you have someone else taking care of him/her?

**Peer Time**
1. Are friends/family taking care of elders too?
2. Do you think that you are very different by taking care of _____, than others your age?
3. What do you think others (in/of your age group) are doing with caregiving needs?
4. How has caregiving affected having friends your own age?

**Intergenerational time**
1. When and how was the decision made that you would become the caregiver?
2. Tell me how you came to be your _______ caregiver?
3. How does caregiving fit into your family life?
4. How does your present life compare with what you thought it would be at this time?

**Social Service Time**
1. Are you receiving any help from caregivers outside the home?
2. How long have you been receiving help?

**Acculturation:**
1. Where were you born?
2. Where was your ______ born?
3. Which holidays do you celebrate and how do you celebrate them?
4. What kind of differences do you see between Mexicans & Mexican Americans?
5. Between Mexicans & Anglos?
6. Between Mexican Americans & Anglos?
7. Do you have Anglo neighbors?
8. Friends? Family thru marriage?
9. How would you identify your Elder’s ethnicity?
10. How would you identify your ethnicity?

**Other**

1. Why is it important for you to do this?
2. What would you think of yourself if you did not do this?
3. Do you feel angry at times?
4. At what/whom?
5. Is there anything else you would like to tell me about your present situation?
6. If I were to ask you what your elder would say he/she is? Mexican? Etc?
7. What would you say you are?
APPENDIX I
ETHNIC CHARACTERISTICS MATRIX

Ethnic Characteristics Demonstrated by Caregivers with Ethnic Self Identification

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<td>Ø likely to be first generation that arrived in the United States as adults.</td>
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<td>Ø tend to be lower class,</td>
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<td>Ø less educated,</td>
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<td>Ø less socio-economically mobile;</td>
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<td>Ø they are likely to live in barrios.</td>
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<td>Ø appear to have no doubt when self identifying as “Mexicano”</td>
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<td>Ø home may have religious statues and Mexican style of pictures of saints.</td>
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<td>Ø knowledge of Mexican traditions and customs is extensive, especially Mexican national holidays</td>
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<td>Ø relatively little knowledge about U. S. holidays.</td>
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<td>Ø may see dissimilarities in relationships between neighbors, with people living in the United States being more isolated and unfriendly.</td>
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<th>Type II</th>
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<tr>
<td>Ø likely be lower class,</td>
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<td>Ø less educated, and</td>
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<td></td>
<td>barrio residents.</td>
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<tr>
<td>Ø</td>
<td>tend to be first generation, having come to the United States as young adults.</td>
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<tr>
<td>Ø</td>
<td>identify as “Mexican” and don’t see how a Mexican can become an American, once a Mexican, always a Mexican.</td>
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<tr>
<td>Ø</td>
<td>strongly attached to the Mexican heritage, and become disturbed when others criticize it in any way.</td>
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<td>Ø</td>
<td>have adopted the celebration of holidays such as Halloween and Thanksgiving, and do not celebrate some Mexican traditions such as quinceañera (Mexican coming out party) because these are not American.</td>
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<tr>
<td>Ø</td>
<td>prefer speaking Spanish to English, and more comfortable living in neighborhoods of residents of Mexican decent.</td>
<td>X</td>
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<td>Ø</td>
<td>may have positive feelings about Americans, but they don’t necessarily want to become American.</td>
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**Type III**

| Ø | likely to be second generation, better educated, and of higher socioeconomic status. | X | X | X | X |
| Ø | individuals feel that they are both Mexican and American. | X | X | X | X | X | X | X |
| Ø | participate in Mexican customs, but acknowledge their limitations of Mexican cultural awareness. | X | X | X | X | X | X | X | X |
| Ø | selectively participate in both cultural orientations, | X | X |   |   |   |   |   |   |
| Ø | are not equally proficient in both | X | X |   |   |   |   |   |   |
cultures.
Ø interact extensively with Anglos on a daily basis.  
Ø are proud of their Mexican heritage,  
Ø do not identify as Mexican.  
Ø most likely will say they are Mexican American or Chicano, while holding different opinions regarding the term Chicano.  

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<th>Type IV</th>
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<tbody>
<tr>
<td>Ø tend to be second generation,</td>
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<tr>
<td>Ø experienced more socioeconomic mobility</td>
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<td>Ø relatively higher levels of education and occupational status.</td>
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<td>Ø more likely to live outside the barrio.</td>
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<tr>
<td>Ø knowledge of Mexican culture is varied, they are clearly more versed in American values and customs.</td>
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<td>Ø a preference to be identified as Americans of Mexican decent.</td>
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<td>Ø Despite this internalization of American values, these individuals have not, in their own view, achieved complete status as Americans.</td>
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<th>Type V</th>
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<tbody>
<tr>
<td>Ø likely to be third or later generation;</td>
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<tr>
<td>Ø live outside the barrio;</td>
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<tr>
<td>Ø have an urban background.</td>
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<td>Ø self identify as American</td>
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<td>Ø may admit to have Mexican ancestry if</td>
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asked.

| Ø     | can be of mixed heritage, resulting in the individual considering themselves American whose heritage happens to be partly Mexican. |   |   |   |   |   |   |   |
| Ø     | somewhat more educated |   |   |   |   |   |   | X |
| Ø     | not necessarily of higher occupational status, higher income, or greater socioeconomic mobility. | X | X | X |
| Ø     | no Mexican and/or Mexican American cultural influence in their life in perceptible ways. | X | X | X |
| Ø     | do not celebrate any of the Mexican holidays or know their significance. | X | X | X |
| Ø     | acknowledgement of the Mexican heritage, but no conscious effort to maintain it. |   |   |   |
| Ø     | can be inconsistent with their self identification. |   |   | X | X |
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