Validating the Mexican American Intergenerational Caregiving Model

Socorro Escandón

University of New Mexico, sescandon@salud.unm.edu

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Abstract

The purpose of this study was to substantiate and further develop a previously formulated conceptual model of Role Acceptance in Mexican American family caregivers by exploring the theoretical strengths of the model. The sample consisted of women older than 21 years of age who self-identified as Hispanic, were related through consanguinal or acquired kinship ties to an elder, and had provided at least one intermittent service (without pay at least once a month). A comparative analysis method was used to test the existing theory, which consists of four phases: (a) Introduction/Early Caregiving Experiences, (b) Role Reconciliation, (c) Role Imprint, and (d) Providing/Projecting Care. Results substantiated and elaborated all four phases and 14 categories of the existing model. This study provides further evidence that the intergenerational caregiving Role Acceptance model can be used to study Hispanic caregivers in varied geographic locations. It also provides a framework for comparison with other groups of caregivers. In addition, results inform health professionals about the ways in which Hispanic caregivers view caregiving. This information has the potential to increase cultural competence in the delivery of health care to elders and their families.

Keywords

Hispanic, Caregivers, Comparative Analysis, and Intergenerational

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Socorro Escandón
University of New Mexico, Albuquerque, New Mexico, USA

The purpose of this study was to substantiate and further develop a previously formulated conceptual model of Role Acceptance in Mexican American family caregivers by exploring the theoretical strengths of the model. The sample consisted of women older than 21 years of age who self-identified as Hispanic, were related through consanguinal or acquired kinship ties to an elder, and had provided at least one intermittent service (without pay at least once a month). A comparative analysis method was used to test the existing theory, which consists of four phases: (a) Introduction/Early Caregiving Experiences, (b) Role Reconciliation, (c) Role Imprint, and (d) Providing/Projecting Care. Results substantiated and elaborated all four phases and 14 categories of the existing model. This study provides further evidence that the intergenerational caregiving Role Acceptance model can be used to study Hispanic caregivers in varied geographic locations. It also provides a framework for comparison with other groups of caregivers. In addition, results inform health professionals about the ways in which Hispanic caregivers view caregiving. This information has the potential to increase cultural competence in the delivery of health care to elders and their families. Key Words: Hispanic, Caregivers, Comparative Analysis, and Intergenerational

This qualitative study used the comparative analysis method to compare findings from a previous grounded theory study that formulated a conceptual model of intergenerational caregiving in Mexican American families (Escandón, 2006). The aim of securing additional evidence was to increase generalizability and reassurance that the documented Role Acceptance process is found in Hispanic families in a different region of the Southwest. The examination of multiple cases deepens the understanding and explanations while reassuring the researcher that the events and processes in one described setting are "not wholly idiosyncratic" (Miles & Huberman, 1994, p. 172). Although it has been noted that generalizability is not appropriate for qualitative studies (Denzin, 1983; Guba & Lincoln, 1989), "the question does not go away" (Miles & Huberman, p. 173). Additional data answered the question of whether the caregiving model made any sense beyond the sample of previously studied caregivers (Escandón) and whether it was reasonable to think that this model might be useful for other Hispanics in other regions of the United States.

Background

Families in the Hispanic population, which is composed of diverse groups of people, have been characterized as having a strong sense of obligation and strong feelings of loyalty, reciprocity, and solidarity among members of the nuclear and extended family. The family, basic and essential to informal caregiving, is a significant social structure that is the backbone of assistance. Informal caregiving relies on relationships between elders and caregivers, which are often complex, are culturally laden, and undoubtedly affect the way caregiving is viewed, conceptualized, and performed.

The anticipated demographic changes, especially for Hispanics, present a critical challenge for informal family caregivers. Hispanic caregiving has not been well studied, and research on Hispanic eldercare is extremely limited. Hispanic families have been historically noted to be more likely to use family as a resource for solving problems than non-Hispanic Whites (Vega, 1995). As a whole, they are known to migrate toward kin networks, maintaining family ties as a "coveted obligation" (Mindel, 1980), and regardless of their national origin, they have reported 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 (1992) reported that in contrast to Anglos, Hispanics were more apt to agree that aged family members should be cared for by family as opposed to others in a nursing home setting. But the literature also notes that there is no universal Hispanic family type (Hurtado; Vasquez & Rosa, 1999; Williams, 1990) and that societal pressures have possibly caused some changes to the commitment to care for their family members. Williams expresses this perspective and indicates that the "extended family has been disappearing, and among economically advantaged Mexican Americans in urban centers, the extended family is not central to the routines of everyday life" (p. 137). Societal changes have been noted among Hispanics and non-Hispanics in the last 30 years, changes that reflect families are in a "constant state of flux" (p. 4). According to Williams, the Mexican American family is in a state of constant modification, consequently undergoing "fundamental revision" (p. 4). It is speculated that family caregiving among Hispanics is growing increasingly difficult because of this fundamental shift of cultural values.

Demographers predict that the Hispanic American population will continue to grow. Between 2004 and 2030, the number of Hispanics aged 65 years and older is projected to increase by 254% compared with 74% among Whites (Administration on Aging [AOA], 2007). In New Mexico, where this study was conducted, Hispanics comprise 41.2% of the total population. The state's elders, persons aged 65 years and older, have increased by 28.3% from 1996 to 2006 and represent 13% of the total population (AOA). Increased longevity, the projected increase in Hispanic elders, and their need for care because of chronic illness emphasize the fact that intergenerational or familial support of these elders, although beneficial to society as a whole, can be detrimental to the caregiver. Research is needed to understand the issues, design appropriate nursing interventions that support caregivers, and formulate policy that can support caregivers.

Caregiving

The literature on caregiving has continued to grow in both volume and sophistication, but despite this, much remains to be learned at both the conceptual and empirical levels. Farran (2001) concluded from studies reviewed from the 1980s and 1990s that the first decade of this research "focused on describing who caregivers were and what care they provided" (p. 44), whereas the second phase "focused on specific skills family caregivers need to provide care" (p. 44). 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. Dilworth-Anderson, Williams, and Gibson (2002) conducted a review of 59 studies, noting only 16 studies with Hispanics and/or Latinos. According to Jolicoeur and Madden (2002), the literature has been "substantial on informal care of the elderly, [and] primarily from white, middle-class populations...one reason for the specific neglect of Hispanic elders has been the relatively small size of the population" (pp. 107-108). A portion of research has been conducted with family caregivers related to dementia. Meir (2007) conducted an analysis of 24 journal articles related to the Hispanic dementia caregiving experience (published between 1985 and 2003) and concluded that "there is a need to study more broadly and more in depth the caregiving experience" (p. 16) for these family caregivers. The need and demand for research in family caregiving will continue to grow with the projected increase in the Hispanic population.

Conceptual Framework

The conceptualization of the caregiving model in the original study (Escandón, 2006), was guided by Kahana, Kahana, Johnson, Hammond, and Kercher's (1994) caregiver paradigm, which provided a method for exploring the cultural influence on Hispanic family caregiving. Their framework outlines three vertical dimensions labeled as axes: (a) the spatial axis identifies the "who," (b) the temporal axis focuses on the "when," and (c) the transactional axis addresses the "what" in caregiving (Table 1). This framework was adapted with Burton and Sorensen's (1993) time dimensions, which directed the focus to the "social and psychological dimensions" that influence "role perceptions and performances of individuals and families…responsible for providing care" (p. 47) rather than on the traditional concept of time that has been dealt with in terms of "the number of hours per day spent in caregiving activities or the length of time one has been a caregiver" (p. 47). The paradigm's temporal axis addresses historical, kin, peer, and intergenerational time dimensions. These time dimensions define caregiving in terms of: (a) family structure or generational attitudes (historical time); (b) what and how shared understandings with elders and among family members influence who assumes the caregiver role and when (kin time); (c) how entry into the caregiving role affects the entire family (intergenerational development time); and (d) how entry into the caregiving role affects the caregivers' peer relationships (peer time). These dimensions influence both the structure and the functioning of the Hispanic caregiving role.

Table 1. Spatial, Temporal, and Transactional Dimensions of the Caregiving Paradigm[1]

	Personal Caregiving Context (individual level)	
	Informal	

SPATIAL AXIS: **WHO?** (key individuals and groups relevant to caregiving)	Family Caregivers
	    Major family caregiver (e.g., spouse or adult children)
	    Secondary family caregiver (e.g., other family)
	Non-family caregivers
	    Friends, neighbors as caregivers
	Care Receiver
	Caregiver-care receiver dyad	

TEMPORAL AXIS: **WHEN?** (time frames relevant to caregiving)	Length/stage of illness Age/life stage Length of caregiving Cohort/historical influences	- historical time, which focuses on "demographic" changes in family structure or "generational" attitudes about caregiving; - kin time which encompasses "shared understandings among family members" regarding who and when certain family members assume the caregiving role; - 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; and - intergenerational developmental time which relates to the "timing of entry" into the caregiver role.

TRANSACTIONAL AXIS: WHAT? (processes involved in caregiving)	Social support:
	    Perceived/received
	    Given/withheld
	    Negative social
	Interactions	

	Formal	

SPATIAL AXIS: **WHO?** (key individuals and groups relevant to caregiving)	Paraprofessional caregivers
	    Paid helper (supervised by care receiver or family)
	    Agency worker (supervised by formal organization)
	Professional caregivers
	    Physician
	    Nurse
	Social Worker	

TEMPORAL AXIS: **WHEN?** (time frames relevant to caregiving)	Length of employment Length of service Cohort/historical influences	- social service time which involves the "clock hours" when social service agencies offer support to care providers
TRANSACTIONAL AXIS: WHAT? (processes involved in caregiving)	Compliance Work of caregiving Exchange	

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[1] Kahana et al.,1994, pp. 4-5; adapted with Burton & Sorenson's 1993 definition of temporal time, p. 48 for Escandón, S. (2006). Mexican American intergenerational caregiving model, *WJNR, 28*(5), 566

The Model

The process of Role Acceptance consists of three sub-processes (Role Making, Role Recognition, and Role Execution) and four phases (Introduction/Early Caregiving Experiences, Role Reconciliation, Role Imprint, and Providing/Projecting Care; Figure 1).

Figure 1. The Relationship of the Three Subprocesses to the Four Phases of the Caregiver's Role Acceptance: Introduction, Role Reconciliation, Role Imprint, and Providing/Projecting Care[2]
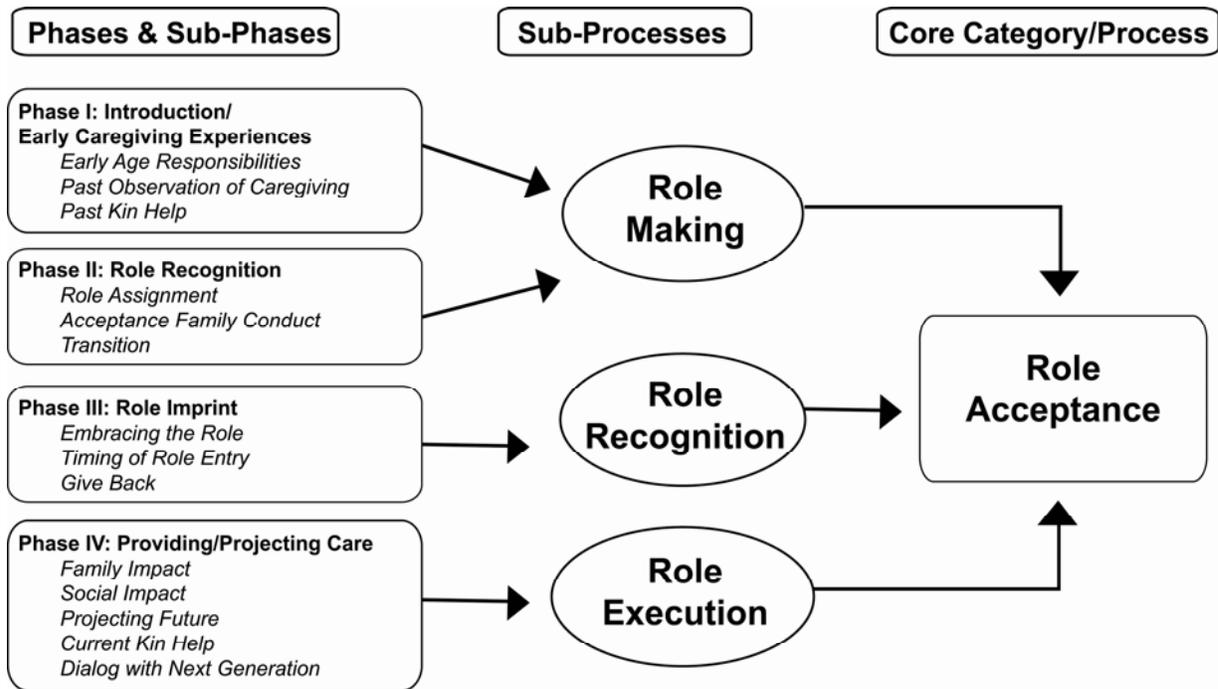
Escandón, S. 2006. Mexican American Intergenerational Caregiving Model. WJNR, 28, (5), p.572.

The emerged core category of Role Acceptance renders how the Mexican American family initiates, nurtures, and passes on the role of caregiver. In this model, Role Making introduces individuals to the caregiving role, incorporating the concepts of tradition and family accountability. In Role Recognition, caregivers consciously clarify and interpret messages received during the Role Making phase. This crystallizes and personalizes the role. Role Execution finds caregivers reviewing their performance and comparing it with the elders' and their own needs, desires, and expectations. This continuous evaluation provides direction for future decisions (Escandón, 2006).

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[2] The first two phases are role making. The third phase, role imprint, is role recognition. The fourth phase, providing or projecting care, is role execution.

Purpose and Study Design

The purpose of this qualitative study was to substantiate and further develop the previously formulated conceptual model of Role Acceptance in Mexican American family caregivers (Escandón, 2006) by exploring the theoretical strengths of the model. It employed a comparative analysis method, which is primarily used within the grounded theory method (Glaser & Strauss, 1967; Strauss & Corbin, 1990) but can be used to continually compare and organize data in further probing efforts to clarify, substantiate, and elaborate an experience or phenomenon (Patton, 2002). Using this open-ended approach allowed caregivers to relate their experiences, thereby allowing concepts and relationships in raw data to be discovered, organized, and compared between the two studies. This method allowed the examination of the existing theory, which consists of four phases: (a) Introduction/Early Caregiving Experiences, (b) Role Reconciliation, (c) Role Imprint, and (d) Providing/Projecting Care; and 14 sub-phases (Figure 1).

Sample

Samples for both studies consisted of caregivers who were considered to be experiential experts due to their perspective regarding the phenomenon of interest (Denzin & Lincoln, 1998; Glaser, 1978). This decision set the boundaries with respect to the research question (Strauss & Corbin, 1990); therefore, only family caregivers were recruited. Participants had to: (a) be older than 21 years of age, (b) be related to a community-dwelling elder through consanguinal or acquired kinship ties, (c) provide at least one intermittent service to the elderly person (without pay at least once a month), (d) live within a 50-mile radius of the elder, and (e) self-identify as Hispanic. Potential participants were identified by purposive and snowball sampling techniques. Sampling continued until category saturation occurred with no new categories emerging (Strauss & Corbin). Recruitment was conducted in Arizona for study #1 and in New Mexico for study #2. Both studies were open to female and male caregivers.

The sample for study #1 consisted of ten female caregivers providing care for ten elders. Caregivers' ages ranged from 38 to 59 years, with elders ages ranging from 59 to 94 years. Most caregivers (n=7) were daughters, one was a daughter-in-law, one was a granddaughter, and one was a niece. Caregivers varied in educational attainment: two had fewer than 12 years, one finished high school, two had some college, one had an associate's degree, one had a bachelor's degree, and three had graduate education. Nine caregivers self-identified as Mexican American, and one caregiver self-identified as Chicano. One elder was born in Mexico, and nine were born in the United States. All caregivers were born in the United States. One participant was a first-generation caregiver, two were second-generation caregivers, four were third-generation caregivers, and three were fourth-generation caregivers.

The sample for study #2 consisted of eight female caregivers. All caregivers self-identified as Hispanic and identified six of the eight elders as Hispanic. One caregiver, who self-identified as Hispanic, was eliminated following the interview because she only "felt" herself to be Hispanic, but in reality was found to be of German/English ancestry. The caregivers' ages ranged from 44 to 73 years, with elders ages ranging from 69 to 89 years. Most caregivers (n=5) were daughters, one was a stepdaughter, and one was a

sister. Caregivers varied in educational attainment; three had fewer than 12 years of education, one had a general equivalency diploma, and three had some college. Five of the seven elders lived with the caregiver in the caregiver's home, one elder lived with the caregiver in a mutually owned home, and one elder had recently been admitted to a nursing home. All caregivers were born in the United States, and all elders had been born in New Mexico.

Approval for this study was obtained from the university's Human Research Review Committee. Written informed consent was obtained prior to each interview. Participants were advised that interviews could be conducted in Spanish or English, or both; all chose English. Participants were advised that they could withdraw from the study at any time.

During undergraduate and graduate education, this author worked as a research assistant with a nurse researcher, later my mentor, whose focus is elders and their caregivers. The work as research assistant provided me with numerous questions regarding caregivers, their siblings and their elders. The research for the caregiving model (Escandón, 2006) is the beginning of that inquiry and was accomplished for a doctoral dissertation. As a Hispanic nurse researcher, I believe that cross cultural research in this area is beneficial to not only healthcare providers in formulating strategies and creating supportive interventions, but to healthcare policymakers. The Hispanic population is changing due to multiple societal influences, the number of elders who will need assistance and care are increasing and research is needed to adequately address these challenges if caregivers are to be supported in their caregiving efforts. This present study is a continuation of my research trajectory.

Method

Interview questions used in study #1 addressed the "changing demography of family, family obligations, synchronicity with friends and colleagues, timing of entry into the caregiving role, use of outside agencies to help with caregiving, and the generational status of elders and caregivers' ethnic self-identification" (Escandón, 2006, pp. 569-570). The original interview questions, which were guided by definitions of the five dimensions of time, were also used for the second study. These questions (e.g., "Tell me about other family members who have been caregivers"; "When did you decide to become the caregiver?"; "Are friends/family taking care of elders too?"; "Tell me about the decision for you to become the caregiver," p. 570) sought to explore, document, and understand intergenerational family caregiving and how decisions are made and carried out.

Caregivers' answers guided additional questions, which clarified their caregiving experience. These open-ended questions allowed the respondents to share their stories, feelings, and experiences of caregiving.

Sample

Recruitment efforts focused on establishing contacts within a moderate-sized city in New Mexico's elder care services. Elder day care facilities were visited and caregivers were approached when dropping or picking up elders by this researcher. Research was

explained, questions answered and participation secured.   Contact information was obtained and interviews subsequently arranged.   A total of seven caregivers agreed to participate.   These seven caregivers were a diverse group of women whose ages ranged from 44 to 73 years.   Five of the seven elders lived with the caregiver in the caregiver's home; one elder lived with the caregiver in a mutually owned home; one elder, having lived with the caregiver, had just been admitted to a nursing home.

Data Analysis

The current study was guided by grounded theory methodology, in which interviews were taped and analyzed using a constant comparative method.   The Role Acceptance processes and sub-processes (from study #1), with their definitions, were used to compare findings in study #2, with the goal of increasing substantive depth, integration, and refinement of the theory.   Participants were asked to answer open-ended questions in one interview lasting an average of one hour.   Interviews were conducted in a setting of the participant's choice, most frequently in the caregiver's home.

Interviews were taped.   These tapes were transcribed by a transcriptionist with identifying data removed.   This researcher reviewed each transcription and compared it to the audio, making corrections as needed in order to obtain an accurate transcription. Transcriptions were entered into an Atlas.ti software program for analysis.   Data were coded after each interview.   The statements and coding were repeatedly checked for fit in the existing Role Acceptance process concepts.   Example of data analysis process and comparison between studies is shown on Table 2.

Table 2. Example of Data Analysis Process; Comparison between Study 1 and Study 2

Study # 1: Raw Data	Study # 2: Raw Data
"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…"	"like…my grandma…there was always the aunties there. My aunts always shared her…she'd stay so long here, so long there."
Statement coded: saw family providing care	Statement coded: saw family providing care
Theme: past observation of Caregiving	Theme: past observation of Caregiving
Phase I: Introduction/Early Caregiving Experience	Phase I: Introduction/Early Caregiving Experience

Data were analyzed for additional codes; themes and concepts. All transcriptions from this study were compared with findings from the first study. Data analysis began with data collection and continued throughout the study.

Establishing Trustworthiness

Prior to beginning interviews, a preexisting detailed journal entry of the researcher's own values and constructions was reviewed in efforts to avoid any commitment to preconceived ideas of what would be found and to augment trustworthiness (Lincoln & Guba, 1985). The researcher's experience with previous research on caregivers continued to be a source of sensitivity because of the existing knowledge of how caregivers speak of their experiences. During the interview, this author restated immediate reflections to participants, provided as feedback that clarified and interpreted the overall theme/category thereby validating what this author was hearing. The intent was to ensure that the theoretical pattern (the theory) fit the data, not to confirm that the data should fit the theory Glaser & Strauss, (1967), in other words, that the theory being tested continued to have 'fit' and 'grab" for the participants. Transcribed interviews were reviewed and corrected while listening to audio tapes. This provided added assurance that statements were accurate. Emergent themes and codes from data set #2 were compared with emergent themes and codes from data set #1 and the relationships among the concepts. Analysis findings, comparison of codes, themes and categories, as well as reflections were reviewed and discussed with peer professionals for confirmation of results (Huberman & Miles, 2002; Lincoln & Guba, 1985). Peers were also asked to review parts of audio that was considered to be difficult to understand and concur on transcription.

Findings

Findings are presented for each of the sub-processes from study #1 and study # 2 to provide a context for comparison of the findings from the present analysis. The first study is reported in significant detail elsewhere (Escandón, 2006).

Phase I

Introduction/Early Caregiving Experiences, characterized by recollections of early age caregiving experiences and responsibilities, defines a time when caregivers became acquainted with caregiving role expectations. This phase consists of three sub-phases: Early Age Responsibilities, Past Observation of Caregiving, and Past Kin Help (past assistance from family members).

Sub-phases. Early Age Responsibilities describes the time when the caregiver became responsible for providing care, as illustrated by this 40-year-old caregiver from study #1: "She had cervical cancer…she was my dad's sister [took care of her]…then…[took care of] her husband…I was the one with him too. So I think I'm going through the same situation." A 44-year-old caregiver from study #2 stated the following: "I used to try to take care of my Dad as much as possible, cause my Dad was sick…so I'd stay home from school…[to] make sure he was okay."

Past Observation of Caregiving, a time when caregivers observed other family members providing care, set the expectation of what caregiving should be, as illustrated by this statement by a 38-year-old caregiver from study #1: "When my dad got real

sick…we talked about him going to hospice, but…that was out of the question,…so I was always there…over two years." A 40-year-old caregiver from study #2 said: "My mom was sick all our lives, she was always sick…so my older sister took care of my mom."

Past Kin Help includes memories that caregivers noted by doing what was needed to be done. A 42-year-old caregiver from study #1 spoke of helping out family members: "I come from a family who has always taken care of the elderly in the family…my grandmother was taken care of by her daughters…so we just carried on with my mom." A 44-year-old caregiver from study #2 said: "With my dad…he had emphysema, bronchitis, and we used to help her [Mom] with my dad."

Some caregivers felt alone and thought that other family members did not help out. A 51-year-old caregiver from study #1 said: "Like my aunt, the last time grandpa got sick, she didn't even come down…other people don't have the same urgency or the same concern." A 44-year-old caregiver from study #2 said the following about taking care of her father: "I have seven sisters and two bothers…just some of us [helped]."

Phase II

In Role Reconciliation, caregivers "consciously acknowledge their agreement with the caregiving role while defining, redefining, and merging" (Escandón, 2006, pp. 573-574) their own personal role identities. There are three sub-phases in this phase: Role Assignment, Acceptable Family Conduct, and Transition.

Sub-phases. In the Role Assignment sub-phase, caregivers relate instances when they "received explicit or implied messages that the caregiving role was ascribed to them" (Escandón, 2006, p. 574). There was no common thread unifying the reasons found. A 42-year-old caregiver from study #1 said: "I started at 13 caring for my mom and my brothers and sisters….I just assumed it [taking care of mother] would happen that way, I never like thought about it, just that eventually, just never like thought about it. I just knew that someday it would happen." A 44-year-old caregiver from study #2 said: "I figured…I would because I was always told that I was the mother hen. My siblings…what do you want to do, how do you want to take care of this…you know, here, you do it."

Acceptable Family Conduct was transmitted to the caregiver through messages that communicated that providing assistance to other family members was a good value to have. A 52-year-old caregiver from study #1 said: "I come from a family who has always taken care of the elderly…my grandmother was taken care of by her daughters up until she died…we just carried on with my mom." A 62-year-old caregiver from study #2 said: "Respectful, watchful, just an expectation. Just the way it was going to be…the way you're raised…raised to respect your elders."

In the Transition sub-phase, the elder is still able to live by himself/herself, but the caregiver begins to anticipate the future. These thoughts begin to shape their future role as caregivers and influence their plan of action. Transition also finds the caregiver witnessing the elder's worsening condition, which will lead to the need for hands-on care. When undeniable changes occur, the plan of action regarding future residence for the elder begins to take shape. The elder will either live with the caregiver or the caregiver will live with the elder.

The messages of what is to come can be implicit or explicit. A 58-year-old caregiver from study #1 said: "When [mother's live-in partner] left her…she had a mental collapse…physically she was okay, but emotionally…mainly companionship…and 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." A 62-year-old caregiver from study #2 said: "[mother asked father] where do you want me to stay? [she still had her house]…go back home or should I stay? He told her no, you stay here where you're taken care of…so this is home to her." A 40-year-old caregiver from study #2 said: "He was here at home and his wife was taking care of him…she was tired…she ended up divorcing him and leaving him."

Phase III

"Role Imprint is a time when the elder's health needs intensify, requiring caregivers to change their behavior" (Escandón, 2006, p. 575). The caregiver, already involved in providing some care to the elder, now realizes the increased need and accepts responsibility for the role. Phase III consists of three sub-phases: Embracing the Role, Timing of Entry, and Giveback.

Sub-phases. Significant events in the elder's life result in the caregiver's Embracing the Role. The elders' increasing needs lead the caregivers to modify their lives. This becomes in some ways a point of "no return" (Escandón, 2006, p. 576). A 54-year-old caregiver from study #1 said: "She [elder] wasn't doing well.…I couldn't turn my, I can't just walk away and not do anything." A 44-year-old caregiver from study #2 said: "When it came time that they [released] her from the hospital…nobody [siblings] opened their mouth. I said…I guess I'll take her…and I took her. Mom needed help…I took it on. I did."

"The Timing of Role Entry sub-phase reflects the time of role acquisition, and its synchronization with peers finds the caregiver either identifying with others because of mutual circumstances or feeling alone with no one to understand" (Escandón, 2006, p. 576). Some caregivers found their situation to be better than that of their friends. Most caregivers in both studies knew someone, either friend or family, that was engaged in caregiving or anticipating becoming a caregiver. This common ground allowed the exchange of feelings and experiences, yielding feelings of solidarity, of knowing that they're not alone, that there are others "out there doing the same thing." A 50-year-old caregiver from study #1 said: "They [friends] take care of them [mothers and fathers].…One of my cousins stays with her father.…Even friends at work, they say, I have to go see mom before I go home, or I have to make dinner for mom before I go home, so it's not only me at school, my friends are doing the same thing. I get together with them, they understand it a lot better 'cause they've been there." A 44-year-old caregiver from study #2 said: "They [friends] understand why you want to scream. They understand completely that it's that emotion that gets you at the end of your rope some days…when you don't have that I think it's difficult."

Some caregivers voiced the aloneness they felt when friends did not share the experience. A 58-year-old caregiver from study #1 said: "I talk to [a friend] because she

calls me, I never call her. It seems it's always in a most inopportune time. She is not doing that caring number, her mother passed away rather quickly." A 44-year-old caregiver from study #2 said: "They [friends] don't quite understand your situation…it gets to be kind of lonely."

"The Giveback sub-phase reflects ways caregivers come to view the experience as normative, allowing them to commit long-term to provide care to the elder" (Escandón, 2006, p. 576). Caregivers from both studies expressed a desire to reciprocate in some way to the elder for what they had received in the past. A 54-year-old caregiver from study #1 said: "I just assumed it [taking care of mother] would happen that way.…I just knew that someday it would happen, like they say, they took care of us when we were young, it's our turn now…they're my parents, that's just the way." A 44-year-old caregiver from study #2 said: "Because she took care of me when I needed her and it's sorta like a return favor." A 73-year-old caregiver from study #2 said: "…there came a time or your turn…to pay back…this is only the right thing for me to do."

Phase IV

Providing/Projecting Care "defined as a time when the caregiving role is actualized, represents the day-to-day reality of providing care" (Escandón, 2006, p. 577). At this time, caregivers and their families are required to make changes in their lives resulting from the decision to accept the role of caregiver. Families often need to alter daily routines and social activities. Eventually, the families providing care must face the reality that even though they provide all the care possible, the elder's condition may not allow him/her to remain with them until death. During this time, caregivers send messages to the next generation. Caregiver dialog is found to both endorse and reject the role. This phase consists of five sub-phases: Family Impact, Social Impact, Projecting Care, Current Kin Help, and Dialog with Next Generation.

Sub-phases. "The Family Impact sub-phase reflects the modifications family members make to execute the caregiving role" (Escandón, 2006, p. 577). Caregivers note instances where their privacy has been invaded, personal relationships destroyed, and opportunities for family time lost. A 50-year-old caregiver from study #1 said: "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." A 44-year-old caregiver from study #2 said: "It changed my life totally. It changed my kids' life totally, because they were young and I had to still work."

"The Social Impact sub-phase reflects changes caregivers make in their friendships and social lives, adjusting to the demands of providing care" (Escandón, 2006, p. 577). The impact on the elder's ability to function and the availability of assistance from others varies. A 58-year-old caregiver from study #1 said: "...[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." A 66-year-old caregiver from study #2 said: "My friends and I talk…I never done anything that I regret…I have no regrets in life…I can do what I want to do…I go shopping, I go to the movies, I go [on] vacations." A 44-

year-old caregiver from study #2 said: "I just moved in with this guy…for about a month already….He seems to be okay with it…it's stressful on your social life, on your relationships, you know…there's no doubt about it."

Caregivers from both studies refer to their social time as part of family time. A 66-year-old caregiver taking care of her sister said: "My grandchildren, they adore their grandma. They take me here, they take me there…they come and do things for me…my daughter…now that the baby is little, well we bring lunch to the house and my daughter on her lunch hour she comes over so we always every day we spend together"

The Projecting the Future sub-phase is a "time when caregivers reflect on their performance and contemplate what they will do when the elder's condition worsens to the point that the caregiver is unable to provide the needed care" (Escandón, 2006, p. 578). Caregivers want to maintain the elder in a family environment, realizing they may need outside help in the future. A 38-year-old caregiver from study #1 said: "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…to clean her, bathe her; I had a heck of a time…I'm so short…[sister] was saying she wanted to bring someone in, but…maybe he'll change his mind…maybe." A 62-year-old caregiver from study #2 said that the "plan is to take care of her as far as we can, to the point that we can't…to the point that she can't, like a vegetable…I don't think I can do that…if we hire someone to take care of her at home, we can do that." Caregivers realize that the situation may get worse and that it is easier in some instances not to think about it, whereas others recall instances that tell them there are little choices to make as the elder progresses in his/her terminal state.

A 58-year-old caregiver from study #1 said: "…she [the elder] 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 I…kinda…like don't do that to me." A 44-year-old caregiver from study #2 said: "We went to go see an aunt at a nursing home once and, well she went with us…she was really worried that we were going to leave her there. Because she saw all these people…and she said, 'I'm not going to stay here right?' 'No, you're not going to stay here.'"

The Current Kin Help sub-phase "provides examples of the type of assistance (i.e., transportation, getting groceries, and running errands) other family members contribute in support of the caregiver and the elder during the caregiving experience" (Escandón, 2006, p. 578). A 50-year-old caregiver from study #1 said: "So my twin…whenever my dad needs to go somewhere, he calls her up and she comes over and stays with my mom….There isn't one [brother or sister] that feels more…it's just that way…if I needed something, I wouldn't hesitate to ask [siblings]….I call and someone helps out." A 62-year-old caregiver from study #2 said: "...two sisters, we try to…take turns…so she will spend a week with my little sister and a week with my other sister, and we try to keep it going that way…so she's got her own bedroom and bathroom in each house…she knows where her own room is and everything…that's what we're doing right now so that all of us have a break."

This type of help is not always available, and some caregivers resent the fact that sometimes the help they receive has to be requested. A 59-year-old caregiver from study #1 said: "…now if I want help, I have to holler….Sometimes she [sister] does [help], and other times it's one excuse after another why she can't….My brother…we had made a pact…he doesn't like to have her at night….He says, I'll come and get her, she can spend

the day, and you can do what you want…that was good for a couple of times, I don't know what happened." A 44-year-old caregiver from study #2 said: "I had to go to a training to write grants [asked sister for help]...[sister] said she would get back…days passed…why couldn't she just have said yes, why did she have to think about it, or check her calendar?"

Table 3. Phases, Subphases, Essential Characteristics of Phases, Subprocess Definitions, and Essential Characteristics of Subprocesses[3]

Phase	Sub-Phases	Essential Characteristics of Phase	Sub-Process Definition	Essential Characteristics of Sub-Process
I: Introduction/ Early Caregiving Responsibilities	Early Age Responsibilities Past Observation of Caregiving Past Kin Help	Caregiver having first-hand experience	Role Making-- caregivers introduced to and begin anticipation of caregiving role incorporating family tradition, accountability, and input from elder	Process is interactive and requires input from the elder and from the caregiver
II: Role Reconciliation	Role Assignment Acceptable Family Conduct Transition	Designation by family members Individual feeling responsible		
III: Role Imprint	Embracing the Role Timing of Role Entry GiveBack	Status change of elder and role acceptance by caregiver	Role Recognition-- instances caregivers consciously clarify and interpret messages received during role-making phase; clarification crystallizes and personalizes role	Clarification and interpretation crystallize and personalize the role
IV: Providing/Projecting Care	Family Impact Social Impact Projecting Future Current Kin Help Dialog with Next Generation	Realization of consequences, adaptation, and adjustment in family function	Role Execution-- instances caregivers review their performance and compared it with elders and their own needs, desires, and expectations.; evaluation continuously occurs, providing direction for future decisions	Continuous evaluation occurs, providing direction for future decisions

The Dialog with Next Generation sub-phase "reflects messages given to children of caregivers regarding future family caregiving" (Escandón, 2006, p. 578). A 50-year-old caregiver from study #1 said: "I never have actually…said it [to daughter], but I've always felt that if the day came she [daughter] would probably care for me, she 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

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[3] Escandón, 2006, p. 566

you.'" A 62-year-old caregiver from study #2 said: "We are the one that cares, when we show her so much love, you know like my daughter says to me, 'Mama, people don't die so much of sickness, they die of loneliness, cause nobody cares nowadays.'"

Not wanting to be a burden, some caregivers wonder what it will be like when they need care. A 50-year-old caregiver from study #1 said: "It's very difficult and where would I be if no one took care of me? Would I fall back on my kids, would it be their responsibility, would I be able to go to a home?...I look at things like that in the future, what if I were in her situation?" A 73-year-old caregiver from study #2 said: "I told them I don't want them to….I could go into the nursing home…you have your family, you have your son…your daughter…your grandkids….I don't expect them to…I just pray and pray…that I happen to die." Table 3 shows all four phases, sub-phases, and essential characteristics of each phase, sub-process definitions, and essential characteristics of sub-processes.

Discussion

Findings in this study continued to document the Role Acceptance process for Hispanic family caregivers. All phases, sub-phases, and sub-processes of the emerged caregiver model in study #1 were substantiated in study #2. Data continued to show that Role Making begins early in the life history of the caregiver, exemplified by early caregiving experiences in the form of either actual hands-on assistance or observed care activities.

Family members who ascribe this role to these caregivers are instrumental in the emergence of the role identity. Caregivers expressed how siblings had always designated them, "…always told that I was the mother hen…you know, here, you do it," according to one caregiver. This finding is consistent with research findings that individuals acknowledge the "inculcation of familistic values…as an important factor in their decision" to provide care (John, Resendiz, & De Vargas, 1997, p. 152). Findings that are consistent with the symbolic interactionist perspective describe aspects of primary socialization and gradual acquisition of basic interactive skills. The aspects noted are those described by McCall and Simmons (1978) as: "(a) the emerging sense of self and other, (b) role learning and anticipatory socialization, and (c) the development of expressive skills" (p. 203).

As the role evolved and transition occurred, caregivers began to recognize their future role, which was noted in how elders were brought to live with the caregivers when there were concerns that the elders might not be eating well or that they might fall and hurt themselves. The decision to have the elder live with the caregiver in most instances occurred prior to the elder's becoming physically impaired. These findings were consistent with study #1 and with Phillips, Torres de Ardon, Komnenich, Killeen, and Rusinak's (2000) proposal that Mexican American children may have a propensity to protect their aging elders; therefore, they assume the caregiving role when their elders are less functionally impaired.

Once the caregivers find themselves cohabitating with the elders, their roles evolve and develop as the needs of the elders increase and the family structure changes. These changes in their responsibilities for the elders enable the sub-process of Role Recognition. This process influences and changes their lives and behaviors, and provides

a new identity and meaning to the caregiving role, one that philosophically fits with the symbolic interactionist perspective as caregivers come to terms with the increasing demands of the caregiving role (McCall & Simmons, 1978). "Identification of persons and of other 'things' is the key to symbolic interaction" (p. 62), and findings from this study are consistent with those of study #1, where once individuals identify and establish the meaning of their assignment (Role Recognition), they systematically place all caregiving messages from the past, coupled with the present circumstances, into their perspective temporal files and accept the roles and "dutifully [fulfill] them" (p. 220).

Role Execution finds caregivers' family structure affected, especially their children's need to adjust to the demands; one caregiver stated that the caregiving situation accentuated difficulties in her marriage, which ended in divorce, whereas others stated that their significant others were very understanding and helpful with the needs of the elder. Another caregiver shared that a friend was in the same caregiving situation and found comfort because her friend had it "worse" than she did. Only one caregiver did not have friends, but she felt that her family was always there to help her. These caregivers found approval and support from others, which is consistent with findings from Burton and Sorenson (1993), who studied multigenerational African American families, noting that group solidarity with peers provides positive feelings and support for the caregiving role. These peers are willing to listen, empathize, and offer constructive suggestions based on their own life experiences.

Caregivers execute their role by establishing a working agreement with their elders and other family members, although much coordination with others is necessary to keep them helping out consistently in executing care activities. Caregivers often voice disappointment that siblings either do not help often enough or have to be asked for assistance.

Conclusions

The original study explored the time dimensions in Kahana et al.'s (1994) paradigm, which addresses the process by which individuals come to the decision to accept the role of caregiver for their family member. Their framework, adapted with time dimensions (Burton & Sorensen, 1993), addresses the "social and psychological dimensions" (p. 47) of "who," "when," and "what" in caregiving. Data from the original study, which used a grounded theory methodology, formulated a conceptual model of intergenerational caregiving among Mexican American families. This model of Role Acceptance is composed of four phases: (a) Introduction/Early Caregiving Experiences, (b) Role Reconciliation, (c) Role Imprint, and (d) Providing/Projecting Care (Escandón, 2006).

This second study continues to document the caregiving process. Caregivers learn lessons from messages and images in all phases. Findings substantiate the original conclusions that individuals' actions and interactions are fashioned by the past and influenced by the expectations of the future when they accept the caregiving role. The symbolic interactionist perspective philosophically fits these caregivers as they come to terms with the increasing demands of the caregiving role. Their role evolves and develops as the needs of the elder increase and their family structure changes. This process influences and changes their lives and behaviors, which provides a new identity

and meaning to their caregiving role (McCall & Simmons, 1978). The caregivers' life histories and interactions "channel the course of today's whos, whats, whens, and wheres" (p. 200). The relationship between the phases of the Role Acceptance theory and the temporal sub-processes of Role Making, Role Recognition, and Role Execution of the caregiving role were substantiated. Findings have provided depth to the context of what it means to be an intergenerational family care provider within the Hispanic culture.

Researchers can continue to explore the caregiving attitudes of elders, siblings of caregivers, and children of the next generation to identify the changes that society has brought and will bring to this population. The history of relationships between caregivers and care receivers within their particular cultural–ethnic traditions influences the provision of care to family members. Many unanswered questions remain, such as: "What messages do siblings of caregivers receive? Are these messages the same as the caregiver? Why do some siblings help with caregiving, when others do not? What messages are children of the next generation receiving? How will these affect their decisions to give care?" (Escandón, 2006, p. 583). Research should continue because "culture is not static and social change based on cultural contact and assimilation [occurs]" (Mindel, 1983, p. 208). We should not expect that all Hispanic families will take care of their family members. The family situation should be critically assessed before determining what types of interventions are needed to provide adequate support for caregivers. The changing demographics, especially for Hispanics, present a crucial challenge for informal family caregivers.

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Author's Note

Dr. Escandón earned a Diploma in Nursing from Hotel Dieu School of Nursing; a Bachelor in Health Administration from Northern Arizona University; a Bachelor of Science in Nursing, a Master of Science and a Doctorate of Philosophy in Nursing from the University of Arizona. Dr. Escandón has been involved with nursing since 1969. She has been a critical care nurse; a nurse manager of critical care units, and a community nurse case manager. Her content areas in nursing education are nursing administration, community nursing, instrument translation, and geriatric nursing. Dr. Escandón's research interests are intergenerational family caregiving, grounded theory and instrument development. Correspondences regarding this article can be addressed to: Socorro Escandón PhD, RN, Assistant Professor, University of New Mexico, Health Sciences Center / College of Nursing, MSC09 5350, 1 University of New Mexico, Albuquerque, NM 87131-0001; Telephone: (505) 272-4556; Fax: (505) 272-8901; E-mail: sescandon@salud.unm.edu

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