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Collective Care: Multiple Caregivers and Multiple Care Recipients in Mexican American Families

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Abstract

Purpose—Specific stressors associated with caregiving in Mexican-American (MA) families are not well documented, yet caregiving issues are paramount because informal care for parents is central to their culture. Although MA families who band together to provide care for one member are not unique, the literature does not describe the phenomenon of collective caregiving, which may be widespread but unrecognized. Such families are both understudied and poorly served by contemporary health systems because their characteristics are unknown.

Design—Descriptive, multi-site, longitudinal mixed-methods study of MA caregiving families.

Findings—We identified three types of collective caregivers: those providing care for multiple family members simultaneously; those providing care successively to several family members, and/or those finding themselves obliged to accept care during their caregiving of others.

Discussion and Conclusions—Collective caregiving of MA elders warrants further investigation.

Implications for Practice—Exploration of collective caregiving may provide a foundation for tailored family interventions.

Keywords

Cultural diversity; Mexican American; family caregiving; caregiving models

Caregiving in Mexican American Families

The Need for Knowledge about the Caregiving Trajectory

The specific stressors associated with caregiving in Mexican-American (MA) families remain to be documented, yet caregiving issues are paramount because informal care for parents is central to their culture (Dilworth-Anderson & Gibson, 2002). In addition, their caregiving trajectory is complicated by factors such as immigration, acculturation, and specific cultural guidelines, such as those associated with *la familia*, where the family is the main source of social interaction, transcending socioeconomic status or gender (Becerra & Shaw, 1984). *La familia*, in particular, influences MA caregiving and knowledge about the ways it creates a distinctive caregiving trajectory is needed since MAs experience more health disparities than Anglos which result in earlier and more severe health deterioration that increase the likelihood of disability and need for care (Espino & Burge, 1989; Espino, Neufeld, Mulvihill, & Libow, 1988). Moreover, the values of *la familia* appear specific to sociocultural contexts that affect how they are perceived and implemented creating additional complexities (Losada et al., 2006). Although MA families who band together to provide care for one member are not unique, we found nothing in the literature concerning the phenomenon of collective caregiving in MA families encompassing providing care for multiple family members simultaneously, providing care successively to several family members, and accepting care during their caregiving of others. Such families are both understudied and poorly served by contemporary health systems because their characteristics and needs are not yet known.

Mexican American Informal Family Caregivers

The U.S. Hispanic population is on the upswing, potentially tripling in number between 2008 and 2050 to 132.8 million and constituting 30% of the nation’s older population (U.S. Bureau of the Census, 2010). A national study on Hispanic family caregiving in the U.S. estimates there are roughly 8,147,000 Hispanic caregivers in the US, with 35.6% of Hispanic families actively engaged in providing informal home care and an average of 1.83 caregivers per household (Evercare and National Alliance for Caregiving, 2008). Even with increasing acculturation and socioeconomic status, l*a familia* continues to drive elder caregiving, requiring strong support and intergenerational reliance. Most MA caregivers feel a need to reciprocate for care given them by older family members and a familial and moral obligation to unconditionally assist their parents (Angel & Angel, 1997; Clark & Huttlinger, 1998; Hurtado, 1995; Schaffer, 1996). In fact, Hispanic caregivers are almost twice as likely as Anglos to reduce work hours or quit work to provide informal care (Covinsky et al., 2001) and they tend to remain in caregiving roles longer, although this may vary by factors like level of acculturation and positive aspects of caregiving (Mausbach et al., 2004). Consequently, family caregiving may result in high levels of caregiver strain, with deterioration in physical and emotional health (McMillan & Mahon, 1994; Yaffe, 2002). When the collective nature of the MA family is added to the mix, a pressing need for knowledge about the phenomenon of MA multiple caregivers and care recipients emerges.

Life Course Perspective and Collective Care

Collective caregiving within MA families, who comprise 66% of the Hispanic population (U.S. Bureau of the Census, 2010), lends itself to exploration with the organizing framework of *life course perspective* (LCP; Elder, 1995; Elder, Kirkpatrick, Johnson, & Crosnoe, 2003; Evans, Crogan, Belyea, & Coon, 2009), a leading framework for the longitudinal study of health and behavior patterns. LCP looks across the life span at cultural and contextual influences, timing of life events, adaptive strategies, trajectories, transitions, and turning points. Cultural and contextual influences include previous historical or individual events that impact the caregiving trajectory and socioeconomic status (Elder, 1995; Elder et al., 2003; Evans et al., 2009; Hertzman, 2004; McDonough & Berglund, 2003). Timing of life events is critical because experiences such as immigration may affect caregivers' adaptive strategies (Gallagher et al., 2002; Goodwin, Hoven, Murison, & Hotopf, 2003). Transitions (changes in responsibilities) and turning points (major transitions where life takes a different direction) affect the caregiving trajectory (pattern of behavior across time). MA families adapt to these transitions and turning points to facilitate informal caregiving. This paper presents a sub-analysis of our recently completed, mixed methods, longitudinal, multi-site, qualitative descriptive study of 110 Mexican American families providing informal care to older family members (Evans et al., 2009). We will describe the understudied phenomenon of multiple caregiving in Mexican American families, asking, "How do MA families adapt to the informal care needs of more than one older family member?"

Methods

Design

We used a case-oriented, qualitative descriptive design (Sandelowski, 2000) with a concurrent, complementary, quantitatively-driven, variable-oriented component to search for similarities and differences, identify broad patterns, and enable the drawing of inferences (Morgan, 1998; Morse, Niehaus, Wolfe, & Wilkins, 2006; Ragin, 2000). These approaches were integrated during data analysis and interpretation (Creswell & Clark, 2007). Data from MA caregiving families were derived from standardized instruments and semi-structured interviews (6 home visits; 10 week intervals; over 15 months, involving multiple caregivers and care recipients).

Sample and Setting

The sample for this sub-analysis included 16 MA families, comprised of 22 primary caregivers (individuals who provided assistance with two or more ADLs) and 25 care recipients, who lived along the U.S. border, an area with multiple economic and health barriers (Salda, Dassori, & Miller, 1999). We originally defined a "case" as a single caregiver-care recipient unit but quickly encountered families who did not fit this definition by virtue of the multiple nature of their caregiving relationships. Caregiver criteria included being a family member, 18 years of age or older, with no self-reported mental health issues other than depression (determined by screening), who provided care for a family member 60 years of age or older. We screened caregivers to ensure their ability to respond appropriately to interview and standardized instrument questions, using the CLOX drawing task (Shulman, 2000) which can be validly administered to community-based Hispanics regardless of education or acculturation (Royall et al., 2003). A minimum CLOX score was not required for care recipient eligibility.

Data Collection

Using procedures approved by the Arizona State University Human Subjects Institutional Review Board, we obtained informed consent and collected data in caregivers' homes. Early on, we encountered the presence of multiple caregivers and/or multiple care recipients within our projected 110 cases. These combinations of multiple caregivers and care recipients we in turn called "collective caregivers".

Demographics—We collected demographic data on both caregivers and care recipients, including relationship, age, education, marital status, household income, socioeconomic status, and acculturation (Table 1). We determined acculturation with the widely-used 5-item General Acculturation Index (GAI), an abbreviated version of the ARSMA (Balcazar, Castro, & Krull, 1995; Castro, Cota, & Vega, 1999). This instrument exhibits good internal consistency, with a Cronbach's coefficient of 0.78 (Balcazar et al., 1995). GAI values of 1.00–2.39 identify less acculturated individuals whereas higher values indicate greater acculturation (bilingual/bicultural [2.40–3.69] and highly acculturated [3.70–5.00] persons.

Zarit Burden Interview (Short version; ZBI)—The short 12-item version of the ZBI produces results comparable to those of the full version; Cronbach's alpha is 0.88 and correlations with the full interview are 0.96–.97 (Schreiner, Morimoto, Aria, & Zarit, 2006). Items include, "Do you feel you should be doing more for your relative?" and "Do you feel that your health has suffered because of your involvement with your relative?"

Center for Epidemiological Studies- Depression (CES-D)—The 12-item scale solicits responses to statements such as, "I had trouble keeping my mind on what I was doing", and "I could not get going". Higher scores indicate greater depression, with a score of 16 and above indicating clinically significant symptoms. Cronbach alpha of 0.83–0.88 has been reported in Chicanos (Radloff, 1977; Roberts, 1980).

General Well-Being Schedule (GWB)—The 18-item GWB scale measures overall well-being along with 6 sub-scales of anxiety, depression, positive well-being, self- control, vitality, and general health (Fazio, 1977; Taylor et al., 2003). Items include, "Have you been anxious, worried, or upset" and "Have you been feeling emotionally stable and sure of yourself?" The cut-off scores are 0–60 (severe distress), 61–72 (moderate distress), and 73–110 (positive well-being). Cronbach alpha coefficients of over 0.90 (Taylor et al., 2003).

Katz Activities of Daily Living (ADL) and Instrumental Activities of Daily Living Scale (IADL)—Lawton & Brody's, (1969) widely-used 7-item ADL scale measures performance in basic physical self-care abilities. It is highly reliable and sensitive to changes in elders across cultures in homecare (Sherwood, Morris, Mor, & Gutkin, 1977). The 8-item IADL scale (Kane, 2000) assesses performance in higher-level self-care abilities such as telephone use, shopping, housekeeping, laundry, and medication administration. The IADL is scored one point per item and the scoring range is from 0 (low function) to 8 (high function).

Penn State Worry Questionnaire-Abbreviated (PSWQ-A-A)—The 8-item PSWQ-A scale assesses worry and has a coefficient alpha of 0.90–.92 (Nuevo, Macintosh, Gatz, Montorio, & Wetherell, 2007). Scored on a 5 point scale, total scores ranging from 8–40. Items include, "Many situations make me worry" and "I have been a worrier all my life".

Positive Aspects of Caregiving (PAC)—The 9-item PAC statements assess caregivers' affective states: "made me feel more useful", "enabled me to learn new skills", and "made me feel appreciated" (Hilgeman, Allen, DeCoster, & Burgio, 2007). Higher scores indicate more positive feelings. The measure has a Cronbach's alpha of .89 (Tarlow et al., 2004).

Caregiver Vigilance Scale (CVS)—This 4-item instrument measures caregiver hands-on care as well as supervision or oversight and is valid in diverse populations (Mahoney, Jones, Coon, Mendelsohn, Gitlin, & Ory, 2003). Cronbach's alpha is 0.66 which is sufficient for initial prediction and validation. Scores are in hours and minutes of caregiving.

Interviews—We used a semi-structured interview protocol administered in Spanish or English to explore transitions, turning points, and adaptive strategies in the caregiving experience, reflecting the study's conceptual framework. It included open-ended items such as, "What are the roles and responsibilities of the people in your family concerning caregiving?" "What are the rules for caregiving in your family?" and "How does being Mexican American influence your caregiving?" Initial interviews took about an hour and follow-ups slightly less time.

Data Analysis

Cases comprised of multiple caregivers and care recipients were identified and tagged for exploration. We used case-oriented research methods (Miles, Huberman & Saldana, 2014) to identify commonalities in cultural and contextual phenomena that exerted strong influences over these MA caregiving families. Research technicians, trained for 90% inter-rater reliability by the PI, imported cleaned, verbatim interviews into Atlas.ti (Scientific Software, 2013), identified themes occurring repeatedly in the text, and labeled them using codes based on a manual derived from the literature (Miles, Huberman & Saldana, 2014) and the LCP framework. We then clustered themes with common features into categories reflecting the constructs of LCP and organized the data into matrices that enabled comparison within and across cases. Both case- and variable-oriented data (analyzed using SPSS, version 19.0) were juxtaposed in these matrices in an effort to enhance understanding of the MA caregiving trajectory.

Findings and Discussion

Researchers often integrate findings and discussion in qualitatively-driven studies to explore meaning and produce a credible storyline for the reader (Holloway & Wheeler, 2009; Sandelowski & Barosso, 2002). Such integration allows use of extant literature to illuminate findings while staying close to the data and avoiding repetition, and enables juxtaposition of case-oriented findings with variable-oriented results (Sandelowski, 2000).

Sample Attributes

Collective caregivers (Table 1) ranged in age from 20–81 (mean = 50.7 years); care recipients ranged in age from 60–98 (mean = 79.8 years; Table 1). Four collective caregivers were male (22%), as were 5 of their care recipients (20%). Almost 70% of collective caregivers were married. with about one-quarter having had managerial and technical or mid-level management positions, and 54.5% being skilled or semi-skilled workers. Annual family incomes, with almost 60% of caregivers earning less than $39,999 per year, mirror their educational and employment levels (the median income for 4-person MA households is $40,647, compared to $52,029 for 3.2 people in the general U.S. population; U.S. Bureau of the Census, 2010). Over one-half of collective caregivers remained actively employed and another 45% were unemployed or retired. Sixty-four percent of *collective care recipients* were still married while 28% were widows or widowers. With the exception of spousal status, the characteristics of this caregiver sample were congruent with a 2005 review of 23 studies (Pinquart & Sorensen, 2005) which revealed that minority caregivers, including those who were Hispanic, were younger, less educated, and of lower socioeconomic status than Anglo caregivers.

“*Expected” caregivers* (one caregiver providing care to one care recipient), were similar in mean age, acculturation, and mean years of education to collective caregivers, although fewer worked in managerial/technical or skilled/semi-skilled positions and they were more likely to be unemployed with lower incomes. They also differed slightly in the proportion of male vs. female caregivers, and fewer were married. *“Expected” care recipients* were similar in mean age and gender to collective care recipients but they were much less likely to be married. About twice as many expected care recipients lived on less than $20,000 per year as the collective care recipients, and far fewer made over $40,000 per year, reflecting lower educational levels.

Cultural Adaptation to Caregiving: Collective Care

All 16 cases representing 22 caregivers and 25 care recipients in this sub-analysis were collective caregiving families, with 4 of those 16 cases providing repetitive care and 2 of the 16 cases providing chain reaction care as described below.

Collective caregivers: Singleton and multiple—Collective caregivers were of two varieties: (a) a singleton caregiver providing care to more than one care recipient (10 cases) and (b) multiple caregivers providing care to a single care recipient (6 cases). There were no cases in which multiple caregivers were responsible for multiple care recipients, although other family members may have stepped in to help in limited ways.

Singleton caregiver situations occurred because a previous commitment had been made to provide care; access to formal healthcare was easier from the caregiver’s residence; husbands decreed it; the caregiver was available because he or she did not work outside the home, have a young family to care for, or “have much of a social life”; the designated caregiver was the healthiest family member; or the caregiver needed a place to stay. Daughters seemed to be first in line as caregivers. For example, two oldest daughters had continuously lived with their parents and that automatically made them caregivers as their parents' health declined. A third said, "Because I'm the oldest daughter….they decided to stay with us." Another daughter remembered the decision concerning who would care for her parents: "Everybody just turned and looked at me, 'cause I was the only female…and I had to take them in".

Multiple caregiver situations occurred because there was no one else in the family to take over; prior singleton caregivers were not available to continue care; one or more caregivers had special skills such as financial, legal, or healthcare expertise; more than one person felt most responsible for care; or to "trade off" caregiving duties with one another so as to share the load. Several multiple collective caregivers noted that they began to provide care because of the death of one parent, sometimes moving into the parental home to better accomplish that goal. Two sons described fulfilling deathbed promises to provide care; one of them explicitly recalled the reasons why he and his wife began to care for his ailing mother.

> Her mother took care of her grandmother and my mother took care of my grandmother and both took care of my dad when he was sick…you follow suit by example. I promised my dad on his deathbed…the wrath of God would come down on me if I didn't do it.

Collective caregivers: Repetitive caregiving—Four collective caregivers also provided care for one family member after another, consecutively, and often simultaneously. For example, Immaculata began to care for her mother and, one year later, stepped up to also provide care for her husband who had a devastating stroke. Her son, his wife, and teenage daughter came to live with her and then she provided care three days a week for her great-granddaughter. "Thank God", she says, "I work and I provide for them…I feel good."

Zamora, a second woman who provided repetitive caregiving, had cared for her mother since 1991. In 2004, her father came to her for care and currently, she was also caring for her mother's brother who lived across the street. "He is another one who is getting sick and has nobody now, so I help him and attend to him when he calls". The future of her uncle was uncertain but may eventually represent a third tier of informal care in her home. A third repetitive caregiver, Ursala, recently increased her level of care for her mother, who had lived with her for 34 years, when her husband had a series of strokes and became disabled. Ursala retired and, with her daughter and son-in-law's help, now cared for both her mother and her husband.

Salvador, an older male repetitive caregiver, described the decision to care for his ailing mother, for whom his brother had provided care until he died.

> It was written in stone. Because I was it, my wife fell in right along beside me. We went through a lot of stuff with her mother too, because she passed away [several months ago] with Alzheimer's…. But this is something new, because it's my mother now and it's a big decision I had to make.

Collective caregivers: Chain reactions—Salvador also was caught up in chain reaction caregiving. In this situation, a caregiver becomes temporarily unable to meet the demands of caregiving, and must rely on someone else to provide some or all aspects of care until his or her ability returns. For example, Salvador lifted his mother numerous times a day during the course of caregiving and went on to develop both knee and back problems that required his son to temporarily take his place during Salvador's surgical recovery. Madena and her family also endured chain reaction caregiving as she struggled with major depression. "I spend a lot of time in my room sometimes. When I get home from work and I feel depressed, I stay up there. That affects everybody, the whole family", who were obliged to step up and assist with care.

Adaptation to transitions and turning points—Of the 22 collective caregivers in this secondary analysis, 16 reported that their lives changed dramatically when they began to provide care. Nine caregivers reported that they had become "chained" (*encadenada;* Herrera, Lee, Palos, & Torres-Gil, 2008) to their care recipients, another lamented that she had not spent one day of her married life alone with her husband and children, and another could not talk about her situation without tears. Six families described their life changes, sometimes regretfully, sometimes proudly, in terms of "caring for a child": "As soon as my dad told me, 'Take care of mom', I felt like I was honored [but] I have an extra child, my mom"; "I've got to give them time, like a child. I had to take them in and I always have to make sure I think of them first"; "My parents are like children. I have to keep an eye on them all the time and it's a lot. It reminds me of the time when I was taking care of my little kids. It's another life responsibility". In contrast, others described life changes as unremarkable and adaptations as few, although they still referenced caring for "children". "It hasn't changed much because I'm naturally like that, a caring person. I kind of envision her like a child sometimes, like we're protecting her", noted one daughter, and one son reported that he and his mother cared for his grandfather like "a baby".

Although we know little about the positive effect of caregiving on the MA family, the rewards (caregiver gain) may be similar across ethnic groups for caregivers who feel useful and see themselves as able to handle difficult situations, set an example for their children, and fulfill the obligations of *la familia* (Giunta, Chow, Scharlach, & Dal Santo, 2004; Konstam et al., 2003; Kramer, 1997). With these collective caregivers, family support and a strong commitment to care may have mitigated the difficult aspects of caregiving and turned the focus toward the rewards or caregiver gain, since no one was unwilling to continue care.

Although the age of some caregivers (ages 20, 28, 42, 48, 52, 54, 56, 57) may account for those who described their health as "good", the protective effects or rewards of caregiving (Coon et al., 2004) may also play a part, in that to admit poor health may imply burden, a culturally unacceptable admission. One of these caregivers reported, "I take care of myself so that I can take good care of my parents". Five others noted matter-of-factly that they had weight management, hypertension, diabetes mellitus or joint issues, but none of them connected these problems to caregiving. Two unmarried, retired sisters reported significant health issues with depression (one scored 16 on the CES-D, indicating clinical depression) and back pain, yet viewed caregiving as positive, saying "I'm the baby of 9, that's why I'm here on this earth" and "That's my nature". Two other women caregivers admitted to deteriorating health and both scored 20 on the CES-D. While they did not use the word "depression", they articulated their distress in terms of "stopping life" to provide care and "putting on 30 pounds and not sleeping". Still, caregivers emphasized caregiver gain instead of burden and did not appear to view health problems as a reason to withdraw care. Only three families had ever paid other caregivers to help them, similar to the 2011 findings by Wells, Cagel, Marshall and Hollen.

Only one caregiver struggled with his ambivalence about caring for his mom, perhaps in relation to the expectations of *la familia* and reluctance to admit burden. He blurted out, "It's been a positive change and it's been a negative. I mean, more positive. I'll tell you the truth, I wouldn't recommend it to nobody. I couldn't say I wouldn't recommend it, I'd say, be prepared". This young man was an outlier in his view of honor and reciprocity for care: "I'm doing this because I love and honor her. I really don't owe her nothing, it was her duty to be a parent and take care of me." As an expression of his regard for her, however, he kept her at home, despite the need to provide her personal care. Describing this endeavor, he noted that she was very resistant to being cleaned and would "actually sob…in embarrassment for two weeks, at least". One of two collective caregiver sons in the secondary analysis who provided such care for his mother, he went on to say, "Nothing against women, but I'm a little stronger and I thought I could do it. It just came natural, I didn't question it, I just went for it. I said, 'Let's just get through it'. And we got through it". This taboo-shattering but matter-of-fact approach has been noted in other MA sons who provided personal care for their mothers (Evans, Belyea, & Ume, 2011).

All the other collective caregivers viewed their efforts as reciprocity (Clark & Huttlinger, 1998) for care received as a child and voiced a universal commitment to caregiving, saying, for example, "You needed from them when you were growing up and now they need from you – that's how we honor them. I'm gonna be here with them until they're no longer here with me". Implicit in this commitment was refusal to place family members in nursing homes, although one woman, looking back over her parental caregiving, said, "I'm hoping [my sons] will find the proper people to take care of me, somewhere where there's lots of Hispanics, where we're going to mingle like a family. I said, 'Son, I don't want you to stop living because of me, it's not fair'. I stopped living [to care for his grandparents]." Her son still planned to care for her, despite a persistent cultural taboo expressed explicitly even in this sub-sample.

Auxiliary caregivers included 11 siblings or their spouses, 6 sons or sons-in-law, 7 daughters or daughters-in-law, 2 grandchildren, 2 nieces and nephews, and 2 husbands. Auxiliary caregivers furnish important support but are not always available, leaving primary caregivers overloaded. For example, one frustrated caregiver told her family, "It's like, wait a minute, you guys need to step it up too. I told you guys I had this thing I have to go to, yet you made plans and now I have to cancel mine". Although auxiliary caregiver help was welcome, some caregivers could not count on it, and in fact, some reported feeling unsupported to the point of criticism: "There will always be someone saying something negative but I've gotten to the point where it doesn't affect me anymore. I've told them it's gonna be this way, that's all there is to it". Other recent research is beginning to confirm such findings, reporting that family caregiving support is not as strong as was once thought in the MA community (Herrera, et al., 2008; Phillips & Crist, 2008).

Implications for Practice and Research

Limitations to the study—The sample of these collective caregivers is small, limiting generalizability of a statistical nature. However, we clearly have “something different” occurring in these MA families than is described in the literature. This “something different” warrants further investigation, and could eventually provide a foundation for interventions tailored to these collective caregiving situations, interventions that are “something more” or “something different” from those offered to other caregiving families. Limitations of this study include the possibility of interpreting data as more congruent and representative of collective caregivers than they really are, and the potential for inaccurate interpretation of culturally-based adaptive strategies. Future studies can address these limitations, by testing across new cases, a form of replication (Creswell, 2013; Miles, et al., 2014), and obtaining feedback from culturally and linguistically congruent MA community representatives and research team members.

Trustworthiness—In this sub-analysis, we enhanced objectivity/confirmability (Miles, et al., 2014), by our explicit description of general methods and procedures, including the sequence of data collection and processing, and inclusion of verbatim data in relation to conclusions. We fostered reliability/dependability/auditability with a clear research question, comparable data protocols for all research technicians, and data collected across the full range of times, settings, and respondents suggested by the research question. We offered context-rich description, triangulation of data sources and methods, and data linked to theory, to promote internal validity/credibility/authenticity. We clearly described sample characteristics, discussed the congruence of our conclusions with LCP, and suggested further testing approaches to increase external validity/transferability/fittingness. Finally, we have a clear action and utility orientation because we suggest ways in which this research might be used to support and enhance the caregiving experience in MA families.

Future research—Few studies examine the familial, social, and cultural factors that determine who will act as caregivers for older MA family members, or describe their experiences. To our knowledge, no other literature describes these factors in terms of collective caregiving, offering a fertile opportunity for future caregiving research. This gap may be an artifact of sparse research in these populations, failure to conduct sub-group analyses (e.g., Giunta, et al., 2004; Harwood et al., 2000; Sink, Covinsky, Newcomer, & Yaffe, 2004; Weiss, Gonzalez, Kabeto, & Landa, 2005), or small samples for variable-oriented analyses. In addition, geographically dissimilar samples may make generalization of findings difficult (e.g., Depp, et al., 2005; Gallagher-Thompson, Areán, Rivera, Thompson, 2001; Gallagher-Thompson et al., 2003), and almost all studies focus on negative effects of caregiving, ignoring the benefits received when caregivers act in accordance with cultural norms (Ayalon, 2002).

Although we did not initially recognize nor actively recruit these families in our larger study, 16 of 110 reported collective caregiving. These numbers may signal a trend in these difficult economic times – clustering together, a culturally appropriate adaptive strategy, could provide additional resources or more efficiently utilize those already available. Future research should investigate the parameters of collective caregiving and address the social networks of MA caregivers needed to support such clusters, since these networks may not be as large or as stable over time as once assumed and may have more negative changes in social support than those of Anglos (Phillips & Crist, 2008). Acculturation or socioeconomic conditions such as increased income, improved access to formal support, smaller family size, and geographic distance may also change the availability of social support or even influence the evolving cultural values of *la familia* (Radina, Gibbons, & Lim, 2009). The increasing numbers of older MAs living longer with chronic illness and their families who care for them at home for extended periods require additional research related to such trends, along with further exploration of MA caregiving dynamics and nursing home utilization (Herrera et al., 2008).

Even though our work documents the existence of both male and female primary caregivers, much of the current literature assumes that MA family caregiving is gendered (Flores, Hinton, Barker, Franz, & Velasquez, 2009), which may lead to bias in future research. For example, Wells, et al., & Cagle (2011) did not include three male caregivers who expressed interest in their study, judging them as aberrant, based on literature. In general, it is true that MA daughters, wives, or daughters-in-law are likely to be primary caregivers and provide more hands-on hours of personal care than sons or husbands, who tend to provide help with activities such as money management and chores around the house (Evans, Coon, & Crogan, 2007; Henderson, Gutierrez-Mayka, Garcia, & Boyd, 1993; White-Means & Thornton, 1990). However, the caregiving activities of men across cohorts may be involving more personal care tasks (Evans, Coon & Belyea, 2015), and it is encouraging that the NIH sponsored REACH II intervention trial of family caregivers did enroll men, with males representing almost 18% of Hispanic enrollees (Belle et al., 2006).

As the socio-cultural context of care changes, however, viewing MA caregiving trajectories longitudinally and deeply through the lens of LCP allows the identification of emerging trends in families separated by distance, divorce, or economic necessity (Evans et al., 2011). The temporal advantages of LCP offer the ability to examine these changing aspects of caregiving across time and the fluctuating nature of social support (Phillips & Crist, 2008). Using a multidimensional lens facilitates a better understanding of these understudied, culturally and ethnically diverse, informal community caregivers who are a growing priority for *NINR, the NIH Office of Behavioral and Social Sciences*, and the health care system. The importance of this priority is clear. With adequate intervention, older adults can be maintained at home even in multiple caregiving situations, caregivers can avoid debilitating caregiver burden, and costly transition in and out of long term care can be avoided (Schumacher, Beck, & Marren, 2006).

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Table 1

Comparison of Collective vs. “Expected” Caregivers and Care Recipients

	Collective CGs ***n*** **= 22**	**Collective CRs** ***n*** **= 25**	**“Expected CGs** ***n*** **= 94**	**“Expected” CRs** ***n*** **= 94**
Age Range	20–81	60–98	19–79	60–110
Mean	*M* = 50.7	*M* = 79.8	*M* = 53.4	*M* =78.0
Gender				
Male/Female	4 (18.2%)/18 (81.8%)	5 (20%)/20 (80%)	12 (12.8%)/82 (87.2%)	26 (27.7%)/68 (72.3%)
Marital Status				
Married	15 (68.2%)	16 (64%)	53 (56.4%)	22 (23.4%)
Widow/Widower	0 (0%)	7 (28%)	2 (2.1%)	51 (54.3%)
Divorced	2 (9.1%)	0 (0%)	20 (21.3%)	9 (9.6%)
Single	5 (22.7%)	2 (8%)	17 (18.1%)	7 (7.4%)
General Acculturation Index	*M* =19.84		*M* =19.32	
Years of Education				
No formal education	–	0 (0%)	–	15 (16.0%)
Primary school	–	16 (64%)	–	53 (56.4%)
Secondary school	–	6 (24 %)	–	18 (19.1%)
Years of community college	–	3 (12%)	–	6 (6.4%)
Years of university	–	0 (0%)	–	1 (1.1%)
Graduate degree	–	0 (0%)	–	1 (1.1%)
Mean	*M* = 13.00		*M* =11.70	
Socioeconomic Group				
Executive and high-level	0 (0%)	0 (0%)	1 (1.1%)	0 (0%)
Manager and technical	3 (13.6%)	0 (0%)	5 (5.3%)	1 (1.1%)
Mid-level management	3 (13.6%)	1 (4%)	11(11.7%)	1 (1.1%)
Skilled/Semi-skilled worker	12 (54.5%)	9 (36%)	43 (45.7%)	30 (31.9%)
Unskilled worker	0 (0%)	5 (20%)	17 (18.1%)	31 (33.0%)
Other	4 (18.2%)	10 (40%)	17 (18.1%)	31 (33.0%)
Employment Status				
Actively Employed	12 (54.5%)	–	44 (46.8%)	–
Unemployed	3 (13.6%)	–	30 (31.9%)	–
Student	0 (0%)	–	3 (3.2%)	–
Retired	7 (31.8%)	–	17 (18.1%)	–
Work Hours per Week	*M* = 26.5		*M* = 26.6	
Annual Family Income				
Less than $20,000	6 (27.3%)	6 (27.3%)	51 (54.3%)	51 (54.3%)
$20,000–$39,999	7 (31.8%)	7 (31.8%)	28 (29.8%)	28 (29.8%)
Over $40,000	9 (40.9%)	9 (40.9%)	15 (16.0%)	15 (16.0%)