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Latina Daughters and Their Caregiving Roles

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Abstract

Responsibilities and cultural expectations can be somewhat different for Latino males and females. In general, males are expected to be more independent and dominant while females are expected to be more nurturing [1, 2]. Similar to other populations, caregiving for elderly relatives has traditionally been a role adopted by women in Latino cultures [3]. Furthermore, first-born or oldest Latinas are sometimes expected to take on the role of caregiver with younger siblings and/or aging parents [4]. McDermott and Mendez-Luck [5] found that this caregiving role was often cultivated at an early age through a continuous, formal and informal socialization process that was gendered through modeling behaviors and care expectations primarily directed at women in the family rather than men.

Practitioners interviewed in this qualitative study reported that daughters were frequently involved in the overall treatment and care of Mexican-American older adults. Some of the expectations included accompanying the parent to doctor visits or treatment; ensuring treatment or medication regimens were followed; serving as primary caregiver; providing information to providers in order to ensure more accuracy; and providing emotional and social support. For purposes of this article, the terms Mexican-American, Hispanic and Latino/a were used interchangeably.

Keywords: Latina, Daughters, Caregiving, Roles

Introduction

Caregiving obligations are deeply felt in many Hispanic families; even those with few resources traditionally have not hesitated to assume responsibility for aging parents [6]. Responsibilities and cultural expectations can be somewhat different for Latino males and females. In general, males are expected to be more independent and dominant while females are expected to be more nurturing [1, 2]. Similar to other populations, caregiving for elderly relatives has traditionally been a role adopted by women in Latino cultures [3]. Furthermore, first-born or oldest Latinas are sometimes expected to take on the role of caregiver with younger siblings and/or aging parents [4]. In a study conducted by Pharr, et al. [7] highlighting cultural influences on caregiving, the Hispanic American focus group participants described caregiving as a female duty that was often assumed by the oldest daughter. Hispanic Americans portrayed caregiving as an instrumental and defining aspect of the family experience, so much so, that not only were other alternatives for formal care outside of the family not considered, they also were not even known to exist [7]. McDermott and Mendez-Luck [5] found that this caregiving role was often cultivated at an early age through a continuous, formal and informal socialization process that was gendered through modeling behaviors and care expectations primarily directed at women in the family rather than men. In the Latino culture, there is an expectation that female members of a family should consider their own wants, desires, and needs as secondary to the needs of the family, particularly the male members of the family [8, 9].

A study of Mexican American women caregivers found that caregiving was an integral part of being a good daughter, and the most rewarding aspect of caregiving was the ability to fulfill role obligations [3]. Without question, la familia, (i.e. the family) is the hallmark of the Latino culture. Caregiving is so ingrained in the Latina caregiver that the decision to care or not to care for her aged parent or grandparent is something that is done naturally and without question.

When older adults experience mental distress and issues related to aging, many families' roles and responsibilities may become interchangeable [10, 11] and the social, emotional and financial support and caregiving are assumed by the family and their natural support network of friends and neighbors. While these family members could include husbands, wives, children, in-laws, etc., the one that practitioners identified as being most likely to help was the daughter. Daughters often accompany the family member to mental health and health appointments and often encourage the individual to seek and follow through with treatment.

Latina daughters often serve as interpreters to help the aging parents understand the diagnosis and/or treatment. Other obligations may include spending time with family, helping around the house, cooking, and making financial contributions to the family [12].

In one study that examined family roles, practitioners reported the daughter or wife was the most instrumental in assisting their loved one in accessing mental health treatment services. Latina daughters generally worked with the treatment team and went to initial appointments; they also explained the program to the clients and helped get appointments [13].

Practitioners interviewed in this qualitative study reported that daughters were frequently involved in the overall treatment and care of Mexican-American older adults. Some of the expectations included accompanying the parent to doctor visits or treatment; ensuring treatment or medication regimens were followed; serving as primary caregiver; providing information to providers in order to ensure more accuracy; and providing emotional and social support.

Methods

The ways in which Mexican Americans experience mental health and health needs and find meaning for their mental health and health experiences are best studied using a qualitative approach. Therefore, consistent with Padgett's [14] recommendations, a focus group, qualitative methodological approach was used to study Mexican American daughters' influence of the family when it comes to help seeking behaviors and service utilization. As a first step in studying this hard-to-reach population, researchers decided to seek information from treatment professionals working with Mexican American clients. The study relied on focus groups to gather practitioners' perceptions of Mexican American daughters and clients' service and treatment experiences. The researchers recruited 25 mental health practitioners (N = 25) from the South Texas-Mexico border to attend one of three focus groups. The researchers selected mental health practitioners because they have firsthand knowledge of daughters and clients' experiences with mental health and health services. The practitioners were 22 Latinos, 2 Anglo, and 1 Asian-American. The twenty-two Mexican American practitioners spoke English and Spanish. The practitioners stated that all their clients spoke English and Spanish. The purpose of the focus groups in which they participated was to generate diverse ideas. For this reason, all members were encouraged to participate. Researchers collected narratives in summer 2016. The researchers held the focus group discussions at three different locations along the South Texas-México border: McAllen/Edinburg, Brownsville, and Laredo.

The South Texas-Mexico border is predominantly Mexican-American, and most residents are able to speak English and Spanish; however, some residents speak both languages interchangeably at the same time. The majority of mental health professionals chosen for the study were also bilingual in English and Spanish. In general, focus groups should occur in nonthreatening environments with a group of individuals who share certain characteristics to allow for a good group dynamic and greater self-disclosure [15]. After receiving IRB Approval, researchers conducted focus groups in private conference rooms at three agency facilities. The researchers obtained informed consent from all participants in the study. Focus group participants sat around the conference room table and were able to see one another. Two moderators conducted focus groups in the language that the participants preferred (English, Spanish, or a combination of both). Researchers have experience facilitating focus groups. Focus group discussions lasted an average of 60 minutes, and they were recorded for transcription purposes [15]. The researchers followed a list of semi-structured guiding questions and probed for examples, clarification, and/or details from group participants.

The focus group questions centered on the role of the daughters in Mexican American families utilizing mental health and health services. The questions were adapted from Kleinman's explanatory model [16], which is frequently used to examine help-seeking behaviors and culture. According to Kleinman, an explanatory model encompasses the notions a person has about an episode of illness and its treatment as delivered by all those who engage in the clinical process. Explanatory models examine people's cognitive processes based on their cultural knowledge and idiosyncratic experiences. Popular culture and the media inform explanatory models, as do the health care culture and the social network of the individual. These elements guide the interpretation and action concerning health. Individuals form explanatory models to cope with a specific health problem. Explanatory models determine what important clinical evidence is, and how it is organized and interpreted for treatment approaches. Explanatory models assist patients and families in making sense of illness episodes [16].

Analysis began immediately after the focus group discussions. Researchers did not need to make any adjustments to the guiding questions or research protocol. Researchers performed all the content analysis, including conceptual refinement and identification of pertinent categories. Finally, the researchers integrated and interpreted the study findings. The researchers used ethnographic content analysis [17, 18] to analyze the transcripts of the practitioners' perceptions of the role of the daughter regarding Mexican Americans families use of both mental health and health services. Ethnographic content analysis centered on the identification of concepts, collection of narratives, and emergent patterns and categories through repeated study of the content or text. Ethnographic content analysis followed a recursive and reflexive movement between the narratives and the interpretation of those narratives by the different members of the research team. The aim was to be systematic and analytic, but not rigid. The process was oriented toward clear description and definition. According to Altheide [17], the process of qualitative document analysis includes examining the content of the narratives to permit emergence, refinement, or collapsing of additional categories. Ethnographic content analysis enabled researchers to organize the data. Four coders independently coded each transcript one by one with each of the category of family roles. The codes identified keywords, phrases, meanings, and concepts. The authors then met and discussed similarities and potential connections among keywords, phrases, and concepts, within and across the focus groups. Coding discrepancies were reconciled through these discussions. All codes and their meanings are presented in the results. This is a descriptive analysis and was not concerned with prevalence of mental distress.

To enhance the trustworthiness of the collected narratives, the researchers also conducted individual interviews with three of the mental health professionals who also participated in the focus groups to provide an opportunity for "member checking." The interviews lasted 30 minutes. Member checking, or returning to the field to verify our analysis, ensures that our interpretation is on the right track [19]. In the analytic process, we also engaged in modified member checking with some focus group participants by asking them to explain further any material about which we had questions regarding the meanings and the themes that emerged from the transcriptions/ interview recordings.

Results

Mental health professionals agreed that Mexican-American older adults who did seek out services were generally accompanied by someone in the family, and more often than not, it was a daughter. Daughters played different roles including serving as primary caregivers, informants, educators, medication managers and/or assisting with discharge planning. One professional stated, "They're always accompanied by somebody.Their wives or a daughter.The majority of the time, it's a daughter."Another mental health provider concurred, "Daughters are primarily the primary care givers that take the initiative to seek services." Yet another participant added that while some males provide some of the help, it is the daughters who are responsible. "I mean I see it all the time. You have a bunch of you know sons, and it's the daughter (who is) the one that takes charge, you know." Others agreed the daughters provide a lot of the emotional and social support. "I've dealt with the sisters a lot more." "I would say normally it's the sisters, the daughters we deal with. The parents count on them for support."

When asked about some of the roles that daughters take when they accompany loved ones to these appointments, mental health professionals agreed that they frequently serve as a good source of information that might not be provided otherwise. For example, one provider said,

"A lot of times, the family member is the informant, you know, that's who you're going to be collecting the, getting the information from, you know, what's going on, so forth and so on. Sometimes the patients maybe hesitant to kind of divulge information or share information with you correct, but the person that is accompanying them serves as the informant."

One participant explained that having the daughter present during the visit "… (makes a) big difference, big difference, in the conversation…(you learn) what's taking place at home, you know, why this is depression and where the depression is coming from." Still another participant added,

"Yeah, sometimes what I'll notice is when I'm talking to the client and they have their loved one they are not necessarily their spouse but ugh a daughter or sometimes it's a daughter-in-law that comes to the appointment with them ugh as the client is reporting to me on some of the symptoms I can kind of see the loved one, on the side, kind of like giving me the 'that's not really what's happening' so then I kind of ask the loved one, you know, can you tell me, elaborate? So they'll go ahead and describe and then the client will say, "Oh yeah, I do that". You know like they didn't want to disclose it initially, but then when somebody is there to kind of, you know indicate that's not really what's happening, then they will admit, " I do experience that, or yes, I do some of these." So having them there, I guess, it is good to collaborate the information that is being presented by the client."

Ensuring that medication or treatment regimens are understood and followed was another role that was identified by the participants. One participant explained that patients will say, "Make sure, you know, my son or my daughter understands what you're saying about the treatment or the medications." Another mental health provider explained,

"They are involved in their care …. Their daughter comes in and they are involved in their care. They know exactly what's going on, with you know services in women's health, and I'm sure that happens with internal medicine and that they are very involved.They know everything -- all the medications she's taking, why she's taking them, what problems she's experiencing and so forth."

In an effort to explain illnesses, and/or treatment,

…the daughters or sons will jot down all the information and say,'Look mom; this is depression, and you are going through all this; remember we talked about it at home?' So even that, they are actually printing out information for them to read.

Discussion

Daughters often assume the primary caregiving role for older Latinos [20, 21]. Some caregivers described the provision of care as providing them with a sense of utility and a sense of meaningful contribution to the care recipient and to the broader family. These women described caregiving as a manner of fulfilling their desire to "repay" their parents or other family members for past nurturance and care [5]. In this study, the daughter was identified as the most instrumental family member according to participants. Many of the participants stated that older adults relied on their daughters to serve as educators and/or liaisons when speaking to providers.

Daughters communicated with physicians and other providers in an effort to reduce stigma of mental illness or fear of treatment. Daughters helped educate and provide support to their aging parent; thus, helping their parent make the decision to go to treatment. Their assistance was the most important to Mexican-American older adults.

Recommendations

Study recommendations include education of daughters regarding mental illness and health treatment services to Latinos. Agencies need to understand the influence and respect that daughters have in Latino families, and how this role can assist a multidisciplinary team in helping older Latinos with mental health and health service utilization. Among the Latino culture, elder caregiving is seen as a normative and cultural obligation as the family is seen as being *"unidos"* (close) and taking care of the parent or grandparent is a sign of *"respeto"* (respect). Perhaps cultural values of loyalty, familial responsibility and *"respeto"* lead to higher care expectations of the Latina caregiver thereby underutilizing or discouraging the use of formal care services increasing the propensity for caregiver burnout or decline in the caregiver's own health or mental health. Research is also needed to identify how the Mexican family supports a structure of familism in which one female family member takes on most or all of the caregiving duties, even if doing so is detrimental to her health [22]. Additionally, it is important to explore what is being done to support the Latina in her role as the primary caregiver.

Conflicts of interest/Competing interests: Authors report no conflict or competing interest.

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