EXPLORING CARE PROVIDER KNOWLEDGE OF FORMAL OR
INFORMAL CARE SELECTION OF MEXICAN AMERICAN ELDERS

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MASTER OF SOCIAL WORK

by
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Division of Social Work
Abstract

EXPLORING CARE PROVIDER KNOWLEDGE OF FORMAL OR INFORMAL CARE SELECTION OF MEXICAN AMERICAN ELDERS

by

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This study explores the perceptions of health care providers towards how clients select formal or informal care services for Mexican American elders. This qualitative, exploratory study uses Andersen’s Behavioral Model of Health Service Use as its theoretical basis. Data was analyzed using content analysis and manifest coding. For the purpose of this study, a snowball sampling method was used. The participants included ten healthcare providers from the Contra Costa and Sacramento Counties. Information was gathered on the types of services the agencies offered as well as on those individuals within the agency whom worked with Mexican American elders or their families in the selection of care. The following themes emerged when discussing unique barriers to health care access experienced by Mexican Americans in regards to long-term care: language issues, cultural issues, lack of awareness of services, and financial issues.

______________________________
Committee Chair
Maria Dinis, Ph.D., MSW

______________________________
Date
DEDICATIONS

First and foremost, I would like to thank God for guiding me through the right path and allowing me to live through one of my greatest accomplishments. To my parents, Jose and Guadalupe Rocha, who have always instilled in me the value of a higher education and have always been there to help me in any way that they possibly could. To my mentor, Ulises Ochoa, who was always there to listen and counsel me through every single one of my countless academic breakdowns. To my siblings and friends who were always encouraging and supportive of my education, specifically my roommate (Lulz) who pushed me to not stop after my bachelor’s and put up with all my graduate school mood swings. To my fabulous field supervisor, Marilyn Royce, who believed in me and motivated me to achieve things in field I never thought I was capable of doing. To my awesome thesis partner, Michael White, who kept me sane throughout the writing process. I will miss our #ThesisTuesdays, but #TeamWhiteCliff will forever live on. Lastly, and not least, to my first elder client who profoundly touched my life in ways that I could never explain. Thank you for welcoming me into your life and helping me discover my passion for geriatric social work, R.I.P Charles H. <3

-Lizette Rocha

First off, I would like to thank my Mom. I know that you are proud of me, but you should be just as proud of yourself. Your continual love and encouragement provided me with the support that has allowed me to succeed. Next I would like to thank my grandfather, Joe, for his generosity and foresight in putting money away for me to pursue higher education, and Mark Pighin at the Department of Rehabilitation for his sponsorship, both of whom provided me with the resources that have allowed me to succeed. Also, I would like to thank the California Coalition for Youth and all of the amazing people who are a part of it for providing me with the practical experience and personal growth that has allowed me to succeed. Special thanks also go out to my two incredible field supervisors: Olivia Alvarado and Mary Struhs for their patience, insight, and inspiring dedication; you both provided the guidance and instruction that has allowed me to succeed. And of course, I want to thank my friend and colleague Lizette Rocha, who somehow managed to make this otherwise arduous process fun.

-Michael White

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Chapter 1

THE PROBLEM

Introduction

This chapter describes the research question focused on in this project. There will be a description of the background surrounding the research question as well as a statement of the research problem. The purpose of the study will then be identified followed by an examination of the theoretical framework guiding the study, defining of terms used in the study, exploration of the study’s assumptions, a discussion of the study’s possible benefit to society, and a description of the limitations of the study. The chapter will also offer a brief summary of the chapters to come.

This study will investigate the perceptions of health care providers towards how clients select formal (out of home) or informal (in home) care services for Mexican American elders. Specifically, the study will look at the approaches of professional caregivers in regards to the factors affecting clients’ decision making process when choosing a long-term care option for their elderly loved one. Factors taken into consideration for the purpose of the study are: clients’ cultural background, clients’ access to health care, clients’ predisposing factors, and clients’ enabling resources.

When an older adult is confronted with a health crisis, the elder and their families often experience difficulties when considering alternative care options when the existing care arrangement no longer meets the older adult’s care needs, or if the family is unable to provide the care themselves. Making decisions in the search for the best possible care
can often be a very complex and emotionally difficult experience for families as there are many factors that can affect the decision making process. Many of these factors can sometimes differ among families of different cultures so it is important for social workers to be culturally competent in order to better serve and understand the factors that are important for certain families when making these difficult and often emotionally painful decisions.

**Statement of Collaboration**

This project is written through the collaboration of researchers Lizette Rocha and Michael White. Lizette is the main writer of chapter one and Michael the lead writer for chapter two. Researchers worked together and equally on chapters three, four, and five.

**Background of the Problem**

Mexican American elders are one of the fastest growing populations in the country and represent 65% of the fastest growing Hispanic segment of the elderly population (“U.S. Bureau of the Census,” 2010). Additionally, elderly persons in this country, those 65 and older, currently number 40.4 million (“Administration on Aging,” 2011). This makes the investigation of Mexican American elders extremely relevant in our society, specifically the investigation of the type of elder care services they pursue. With such a large percentage of the population being elderly we have to pay closer attention to the types of services that they will require and desire.

Many Mexican American families harbor strong traditional values which dictate the methods of care they will provide for their elders. For example, it is a common
expectation that the eldest daughter of an elderly couple will be the one to care for them (Espino, Mouton, Aguila, Parker, Lewis, & Miles, 2008). This often results in their being a sense of shame or guilt if a family member will not care for their relatives, but instead seek outside help. Another traditional value which serves to influence the selection of care is the belief in a higher power as being responsible for some afflictions (Cagle & Wolff, 2009). This can result in individuals not seeking care for certain issues, as well as keeping certain ailments undisclosed among family members to avoid stigma.

As the United States' population grows older, many people will be faced with the difficult decision of choosing a long-term care option for their elderly loved ones. In 2010 alone, the older population (65+) numbered 40.4 million, showing an increase of 5.4 million or 15.3% since 2000 (“Administration on Aging,” 2011). As our nation’s elder population increases, consideration of the social services available for seniors as well as their long-term care options will be a nationwide concern. Furthermore, another significant change within the elder population in the United States is not only its fast growth in population size, but also its significant growth in ethnic diversity. As multiculturalism increases among older Americans, more research will need to be conducted on the experiences of the minority elderly; Mexican-Americans, in particular, as relatively little has been documented about their approach to long-term care.

Statement of the Research Problem

The aging of our population is important to social work as there will be a high demand for geriatric care services and support for the elderly and their families. As our
nation becomes more culturally diverse, understanding unique cultural influences regarding long-term care will assist social workers in providing appropriate care services. In a study by Trask, Hepp, Settles, and Trabo (2009) researchers focused on the need for culturally competent elder care services in light of our increasingly diverse society. The authors offered interesting statistics regarding the growth of diversity in our aging population. By 2050, 25.4% of our aging population, 65 and older, is projected to be made up of racial and ethnic minorities: those individuals who do not identify themselves as white. This would be a significant increase from the 16.4% that existed in 2000, made up of 8% African American, 6% Hispanic, 2% Asian and Pacific Islander, less than 1% Native American and Alaskan Native. In 2050 however, these numbers are anticipated to rise to Hispanics comprising 16% of the older population, African Americans to comprise 12%, and Asian and Pacific Islanders to make up 7%. The percentage of whites in the aging population is thought to drop from 84% to 64%, a 20 point drop in 50 years. As a result, the field of cultural competence in social work and health care is emerging rapidly. This study will explore factors influencing families when choosing long-term care for their elderly loved ones. An emphasis will be placed on Mexican-American families to explore factors unique to their culture.

**Purpose of the Study**

This study is investigating the perceptions of providers towards how clients select formal or informal (in and out of home) care services for Mexican American elders. This study will strive to identify factors affecting the decisions of Mexican Americans when
selecting care services for their elderly relatives or loved ones. Acquiring further knowledge about these topics will further previous research and help social workers, policy makers, and others in the geriatric care arena better understand the culture and needs of the rapid growing Mexican American elder population. Through the perceptions of Mexican American care providers, we attempt to explore the factors influencing families’ decision-making process when choosing a long term care option for their elderly loved ones.

Furthermore, this study will explore perceived barriers to care experienced by Mexican American elders and their families. Research today shows that there are still barriers that prevent Latinos from benefiting from health care services such as cultural barriers, language barriers, and education barriers, as well as income, tradition, and language barriers (Ochoa Poag, 2010). This study will aim to further analyze these barriers and the role that these barriers play when determining the long-term care options for an elderly loved one.

**Research Question**

What are the perceptions of providers towards how clients select formal or informal (in and out of home) care services for elderly Mexican Americans?

**Theoretical Framework**

A theoretical approach constructive in guiding this study is Andersen’s Behavioral Model of Health Service Use. This framework has been cited as one of the most important theoretical approaches to formal or informal care use as its specific goal
is to provide an understanding of the differing levels of access to health care across groups such as minority groups or persons receiving specific types of health services (Andersen & Newman, 1973; Gehlert & Browne, 2011; Keysor, Desai, & Mutran, 1999). In a 1995 revaluation of his own theory, Andersen reiterates the different predisposing characteristics in a person’s life such as demographics, social structure, and health beliefs; enabling resources such as personal/family networks and community; and lastly the need for health services of each individual (Andersen, 1995).

The first component of the theory, predisposing characteristics, is used to determine the likelihood one will use health care services based on individual characteristics such as demographics, social structure, and beliefs. For the purpose of this study, demographic variables will be identified as one’s age and gender. Moreover, social structure will be measured as one’s education, occupation, and race or ethnicity. Social structure is often seen as the most important component to this model because these specific factors are often the biggest predictors of the types of long-term care services sought or afforded by families. One’s race or ethnicity is also a factor in long-term care placement as much research. Lastly, beliefs will be described as the attitudes, values, and knowledge about services specific to the person’s culture, or in some cases religion. In a study of Hispanic caregivers of seriously mentally ill family members, caregivers reported receiving support from their religious leaders and using prayer when dealing with the frustrations of caring for their ill family member. Additionally, they also reported seeking support from members of their religious congregation and using
religion, spirituality, and prayer as coping strategies for dealing with the stress of caregiving (Espino et al, 2008).

The second component of the theory, enabling resources, is relevant in this study because it determines an individual’s access to personal, family, and community resources. Examples of these can include income, health insurance, formal or informal caregivers, and knowledge and education about resources and care available. The type of relationships and the quality of social relationships between relative and non-relative caregivers is also considered an enabling resource (Andersen, 1995).

Lastly, the third component of the theory, need, can be defined by both perceived need and evaluated need. Perceived need is identified as a personal feeling of the individual or their family system, whereas evaluated need is from a health care professional such as a physician. Need is an important factor to be considered for the study because one’s health status is a strong indicator for long-term care placement decision-making. Change in behavior, memory, cognition, or physical abilities often increase stress and burden for families providing informal care. The elder may sometimes themselves also feel like they are a burden on their family and thus initiate the seeking of a long-term caregiver or a long-term care facility (Nakashima, Chapin, Macmillan, & Zimmerman, 2005).

These are important factors to consider when evaluating long-term care decisions for the elderly as various different dynamics in a person’s life can determine their ultimate decision. Andersen’s model will direct this proposed study as a preliminary
guideline when analyzing the experiences of elderly individuals to determine the utilization or non-utilization of institutionalized long-term care. This analysis will explore the unique cultural characteristics of Mexican Americans that influence their preferred long-term care option and how their experiences may differ from those of the dominant culture. This exploratory study will attempt to contribute to the limited literature on elderly minorities by examining the dynamics of the long-term care decision-making process in Mexican-American families.

**Application of Theoretical Principals**

The Behavioral Model of Health Service Use is applicable to this study as the variables under study are relevant and applicable to the differing phases of the model. The first factor in the model is predisposing characteristics, such as demographics and social structure. For this study, age is a big predictor in this category because it can have a huge role and effect in determining the suitable type of long-term care for the elder. As one ages, the likelihood of more assistance with activities of daily living or medical attention is needed. Furthermore, gender, race, and out-of-pocket home expenditures also play a crucial role in the decision making process and are predisposing characteristics that will be explored in this study as well. The second factor taken into consideration in this study is one’s enabling resources, such as family and community. Personal and family resources for this study are identified as caregiver type, such as if a family chooses a relative caregiver versus a non-relative caregiver. The enabling resources at the community level can be defined by the presence of long-term care insurance coverage,
which can be nearly unattainable for many minority elders that are sometimes undocumented or lack the funds or insurance due to previous low-paid jobs. Lastly, the third factor in Andersen’s theoretical model is need. This can be either a perceived need or an evaluated need for health services (Andersen, 1995). For the purpose of this study, the concept of need will be identified through the level of assistance required in activities of daily living (ADL’s) and one’s health status.

**Definition of Terms**

The following terms are used throughout this paper and are central to the field of geriatric social work.

**Acculturation:** the blending of behaviors and attitudes of the minority and majority cultures in a given society (Crist, McEwen, Herrera, Kim, Pasgovel, & Hepworth, 2009).

**Activities of daily living (ADLs):** a term used in healthcare to refer to daily self-care activities such as eating, bathing, dressing, toileting, transferring (walking) and continence (“Administration on Aging,” 2011).

**Care Providers:** an individual or an institution that provides preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities (Cagle & Wolff, 2009).

**Culturally Competent Health Care:** a health care system that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural
knowledge, and adaptation of services to meet culturally unique needs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

**Curandero:** a healer who uses folk medicine a holistic form of healing, which combines prayer, herbal remedies, rituals, psychic healing, spiritualism, and massage (Higginbotham, Trevino, & Ray, 1990).

**Elderly:** people 65 years of age and older (“Administration on Aging,” 2011).

**Formal (out-of-home) care:** institutionalized care typically in a facility equipped to care for elderly or disabled people unable to look after themselves (Jolicoeur & Madden, 2002).

**Hospice:** a health-care facility for the terminally ill that emphasizes pain control and emotional support for the patient and family, typically refraining from taking extraordinary measures to prolong life (Randall & Csikai, 2013).

**Informal (in-home) care:** Paid medical or non-medical care for the elderly performed in their home by a licensed professional through an in-home care agency or a health-care agency (Jolicoeur & Madden, 2002).

**Long-term care:** a variety of services which help meet both the medical and non-medical needs of people who cannot care for themselves for long periods of time (“Administration on Aging,” 2011).

**Machismo:** The feeling of masculinity, dominance, and responsibility for one and one's family associated with being a man prominent in Mexican American culture. (Cagle & Wolff, 2009)
Assumptions

The following assumptions have been made for this study: 1) care providers have knowledge of clients' cultural background; 2) care providers have information on their clients’ access to health care; 3) care providers have a working knowledge of their clients' family system; 4) care providers can articulate clients' opinions towards formal and informal care.

Justification

The results of this project may assist social workers and other professionals in the field of gerontology and long-term care services. The issues that can arise when deciding the long-term care of an elder can not only be a problem for seniors and their families, but also for social workers and the public service arena. The findings of this study are essential to social workers and the profession at large as considerations must be made to the social services that will be available for our fast growing senior population. As initially stated in the National Association of Social Workers Code of Ethics (2008), section 1.05, social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. As we are now experiencing more cultural diversity among elders with the expanding ethnic minorities in the United States, social workers must be culturally aware and competent to work with diverse cases. The movement toward cultural competence in health care has gained
national attention and is now recognized by health policy makers, managed care administrators, academicians, providers, and consumers as a strategy to eliminate racial/ethnic disparities in health and health care (Betancourt et al, 2003). The implications for assessment, care coordination, and the delivery of services are all areas that can be greatly impacted by one’s own racial group or ethnic identity. As a result, social workers must be educated about the differences in racial groups, their unique traditions and beliefs about aging, and their willingness or unwillingness to accept certain types of long-term care.

**Delimitations**

This qualitative exploratory study only collects surveys from a second-hand source, and not from families of the elder directly for their protection of families. The focus of this study is solely on caregivers’ approach, so results may not be as authentic as those from a direct source. Being a rather small qualitative study, no generalizable statistical data will be derived from this study. Study aims to find common themes among Mexican-American elders’ choices of long-term care options from the perspective of professional caregivers. The interview subjects are limited to ten professionals working in the Contra Costa County in California.

**Summary**

Chapter one encloses an introduction of the topic of study, the background of the problem, a brief statement of the problem, purpose of the study, and an overview of the theoretical framework guiding the study. The chapter continues with definitions of terms,
limitations of the study, and a summary. In Chapter 2, the literature will be reviewed in relationship to the background information on formal and informal care of Mexican American elders, to provide a greater understanding of the problem, and report on what research findings exist. Research methods for this research project will be presented in Chapter 3, while Chapter 4 will present the data obtained from the study results. Chapter 5 will discuss the meaning of the data and present conclusions and areas of further research.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

In the first section, the history is discussed surrounding Mexican Americans and the issues they experience in regards to elder care services. In the second section, the process of acculturation is examined and how it affects Mexican American elders and their families in their choice of care. In the third section, the various barriers to Mexican Americans’ seeking and receiving care will be investigated. The fourth section focuses on the existence of specific ailments and how they may influence selection of care. In the fifth section, the factors specific to hospice use by Mexican American elders will be explored. The sixth and final section will discuss gaps found in the literature.

History of Mexican Americans’ Experience of Elder Care Services

Historically, Mexican Americans families have viewed elder care as something intended to be kept within the family and within the family’s home. The responsibility of taking care of a family’s elders traditionally falls to that family’s eldest female sibling. The custom is for a couple to move in with and be taken care of by their eldest daughter in their old age. If a couple did not have any daughters then they would be taken care of by their eldest daughter-in-law. These traditions go back countless generations among Mexican American families and have remained prevalent to this day (Huber & Sandstrom, 2001). Elders expect to be taken care of by their families in their old age and younger family members consider it their duty to provide such care. These traditions play
a huge role in Mexican Americans' utilization of elder care services today, as will be
discussed in further detail in following sections.

Health care for all individuals, not just elders, in Mexican American culture has
historically been seen to by practitioners known as "curanderos" or "curanderas". A
curandero, which translates to "healer" in English, is a member of the community who
provides cures to various physical, mental, emotional and spiritual ailments that
individuals may be afflicted with. The healing process can vary widely depending on the
type of curandero, some using various herbal remedies, others focusing on different
forms of muscle massage, and others relying on prayer and related faith-based practices.
The type of healing utilized depends on the curandero as well as their diagnosis of the
nature of the affliction (Huber & Sandstrom, 2001). The techniques used by curanderos
run counter to those of western medicine and have historically been met with skepticism
and resistance by western doctors. Because of this disconnect many Mexican Americans
are raised with a mistrust of western medicine and a preference to their own cultural
methods of healing (Higginbotham et al., 1990).

The role of the curandero in Mexican American culture is partly due to the high
value of faith and spirituality. Many ailments and illnesses are historically viewed as
being spiritual in nature, existing as a result of curses from malevolent spirits or
individuals or as lessons sent forth from God. Because of this, cures for such ailments
are often sought out in the form of prayers, blessings, exorcisms or related spiritual
practices, hence many curanderos having catholic practices as part of their healing
practice. This also runs counter to the core of western medicine, which does not factor religion or spirituality into its healing practices (Higginbotham et al., 1990). This has historically created another disconnect between Mexican American's and the common health care systems of the dominant white culture of the United States.

Many Mexican Americans have also entered the United States and found themselves somewhat isolated from much of society due to the dominant culture being quite different from their own. This isolation tends to make individuals feel more and more distanced from their environments and creates the tendency to form smaller communities with others hailing from cultures similar to their own and choose not to reach out to the rest of society (Heine, 2008). This has resulted in many Mexican Americans choosing not to reach out from their own communities to seek formal medical services, even when it gets to the point where they could benefit from them. Many Mexican Americans therefore tend to stay within their own communities practicing their own cultural traditions, which entail keeping elder care within the family and community, and not reach out to the prominent medical and care giving customs of the United States.

These factors have compiled to make it that a very low number of Mexican Americans have historically sought out-of-home elder care services. Despite Mexican Americans being the fastest growing minority population in the United States they have been found to have the lowest utilization of health care services of all racial/ethnic groups in the country (Higginbotham et al., 1990). This is true for all types of health care, and even more so for elder care. Mexican Americans' heritage of caring for elders in the home
and orienting their healing system around deep spiritual and religious beliefs have resulted in their vastly underutilizing available health services over the years. Evidence of this can be found dating as far back as such research on Mexican American healing practices and health care preferences has been conducted (Huber & Sandstrom, 2001). This underutilization, and even avoidance, of United States health care options has endured to this day.

Acculturation

Acculturation is a factor that is frequently discussed in psychological and sociological research. Its influences can be found in any society containing differing cultures, especially those societies in which there are majority and minority separations between these cultures. Such influences can be positive or negative, but either way they are undeniably powerful (Heine, 2008). There is undoubtedly a significant interaction between Mexican American culture and the dominant culture, because of this acculturation is a key factor investigated in the current study.

Acculturation is defined as the blending of behaviors and attitudes of the minority and majority cultures in a given society (Crist, McEwen, Herrera, Kim, Pasvogel, & Hepworth, 2009). Taking this a step further, Kao and An (2012) described acculturation as the process of an immigrant’s culture integrating into the dominant or “host” culture of the society to which they have moved. This process is necessary for many immigrants to effectively cope with their new environments. Those who are able to integrate smoothly into the dominant culture have been found to have far lower levels of depression than
those who have a harder time being acculturated (Zamanian, Thackrey, Starrett, Brown, Lessman, & Blanchard, 2008). This correlation has also been investigated in terms of how it affects individuals serving as care providers to family members.

Family caregivers possessing low levels of acculturation have been found to experience higher levels of stress, a higher sense of alienation, a greater lack of financial and emotional support, and be less likely to use social services in providing care when compared to caregivers with higher levels of acculturation (Jolicoeur & Madden, 2002). Such findings indicate that a failure to become acculturated into one’s society can lead to dissatisfaction in an individual’s life due to a loss of important sources of personal support that may have been present in their past culture. This is important to consider when dealing with elder care, which can be an emotionally taxing and arduous process even with ample support.

A study performed by Salda, Dassori, and Miller in 1999 investigating caregiver burden explored this very phenomenon. Differences in perceptions of caregiver burden among Mexican American and European American (EA) individuals serving as caregivers for family members suffering from a severe mental illness were analyzed. Caregiver burden refers to the feelings of stress felt by caregivers towards their duties. Participants were interviewed to determine their perceived level of caregiver burden, which was then compared to various demographic variables such as income, residence, and ethnic background. Results found a significant interaction to exist between levels of acculturation on perceived caregiver stress.
MAs with higher levels of acculturation reported higher levels of care giver burden as well as displayed greater coping efforts, similar to those of EAs. MAs with lower levels of acculturation were found to have lower levels of caregiver burden. The authors were however cautious to note that differences in the reporting of caregiver burden may exist across context and culture, resulting in an effect on overall findings (Salda, et al., 1999). These findings suggest that the culture of the United States is one that leads towards greater feelings of caregiver burden among family members, being that members of the dominant culture as well as those MAs who had become more acculturated to it reported higher caregiver burden than those who are not. It can therefore be seen that acculturation not only affects whether or not a family will seek out-of-home care, but also affects their own attitudes towards the in-home care they currently provide.

It is agreed that acculturation is a very potent factor in how cultural minorities live within a dominate culture, but many argue that acculturation is not a process that should be one sided and that the dominant culture needs to be willing to make modifications in order for minority cultures to effectively integrate (Heine, 2008). Such modifications would require an awareness of minority cultures operating within the majority culture. An acknowledgement of differing cultures is the first step in working towards successful integration, rather than merely seeking to suppress them as too often happens in the United States (Cagle & Wolff, 2009). A suppression of minority cultures lead to disconnect between those individuals within that culture towards the dominant society
(Heine, 2008). In terms of healthcare, such disconnect can lead to a hesitation to utilize services as well as an inability of such services to effectively provide care. Because of this, factors which affect successful acculturation between cultures warrant careful consideration.

### Barriers to Care

Research has indicated numerous different barriers that exist in impeding Mexican Americans’ awareness and effective utilization of out of home elder care services (Parra & Espino, 1992). While there are many such factors that have been found to exist, three in particular were found to be prevalent in the literature: cultural barriers, language barriers, and financial barriers. All of these factors have been found to trammel both Mexican American’s accessibility to out of home elder care as well as such care’s effectiveness in serving them (Yarry, Stevens, & McCallum, 2007). Each barrier will be broken down into its own section.

#### Cultural

Culture is a huge part of our everyday lives and serves as a guiding factor of our behaviors and roles within our communities (Yarry, Stevens, & McCallum. 2007). Concordantly, culture is a huge influence on an elderly individual’s decision on who will provide care for them when it is needed and how that care giving will be perceived. When working with aging individuals, social work professionals must be competent and considerate of unique cultural values and aware of multicultural issues that can be relevant to the long-term care choices made by seniors and their families.
A nearly unquantifiable amount of cultural issues exist which affect Mexican American’s seeking and utilization of services. One of the most prevalent of these issues however revolves around Mexican Americans’ traditional values in relation to caring for their elders. Mexican tradition dictates that the care of elders is something meant to stay within the family. Care giving is a responsibly which falls to the eldest daughter or daughter-in-law of the elder couple requiring care. Therefore a family seeking out of home services will often experience shame and guilt at not being able to keep care within the family (Espino, Mouton, Aguila, Parker, Lewis, & Miles, 2001). This can make it very difficult to reach out to those families who may need care, and likewise for those families to gather the courage to reach out when they are in need of assistance.

One of the factors which such cultural values regarding elder care can be attributed towards is "reciprocity." This theme was investigated in detail as to its prevalence and influence in Mexican American culture in a study performed by Clark and Hutlinger in 1998. Reciprocity refers to the belief that elders should be venerated within a family, and that younger family members have an obligation to care for them in their old age just as they were cared for in their youth. This was found to be extremely prevalent in Mexican American culture due to the high respect that many Mexican American people have for their elders. Reciprocity is embedded in their culture due to the felt need of giving back to elder parents or elder family members.

Feelings of reciprocitity effect how both the elder and their family caregivers feel towards their care. Elders regret being a burden on their family but still expect to be cared
for in their old age as is custom. Caregivers likewise feel it is their duty to provide such care and are prepared to make the life changes necessary to do so. Such values are taught by elders to their children at a very young age, particularly females, and carried throughout Mexican American culture across generations (Clark & Hutlinger, 1998). By having such a firm belief in place, it runs counter to the usual custom in the United States to leave the care of elders to professionals and institutions.

Another element of Mexican American culture which contributes towards the selection of elder care services is the type of communication that occurs within the family around such issues. Research has been done on what has been termed "implicit" and "explicit" forms of family decision-making. Implicit decision-making involves a lack of verbal communication among family members. Decisions are without talk and are thought to be tacitly agreed upon based on pre-existing family values. Implicit decision-making is regarded among family members as a sign of a healthy family, there is a lack of conflict and a thought that everyone family member knows what is best for the family as a whole. Conversely, explicit decision-making involves direct verbal problem-solving communication between family members. Implicit decision making is found to be very prevalent in Mexican American families, whereas explicit decision making is more common in the dominant white culture of the United States (Radina, Gibbons, & Lim, 2009). This leaves many Mexican American families in a position where conversations regarding possible alternatives to care do not take place and adds to the perpetuation of cultural values against seeking out of home care.
An issue which stipulates from this reticence to seek out of home services is that often times it takes a severe decline in an elder’s health before they or their family finally reaches out. This results in an individual’s ailments becoming more and more difficult to effectively treat by the time they are brought to an institutional setting (Espino, et al., 2008). Mexican American elders therefore find themselves both with severe health concerns as well as in a strange setting, out of their homes and communities and separated from their families for perhaps the first time in their lives.

This holding out until the last possible moment is theorized to also have a spiritual component derived from Mexican American cultural values. Research conducted in 2009 by Cagle and Wolff looked into the perceptions of Mexican American family caregivers towards their family members’ cancer diagnosis. The themes found involved: the interpretation of cancer as punishment, the caregivers’ fear of the cancer diagnosis, the high value placed on maintaining hopefulness and optimism, the tendency to selectively disclose medical information to the patient as well as other family members, and trust in the abilities of God and the doctor.

All of these themes are theorized to stipulate from the deeply religious attitudes found in many Mexican American families. Cancer is viewed as an affliction sent forth by God as punishment for some form of misbehavior by that person at some point in their life. Caregivers are therefore hesitant to inform their family members of such a diagnosis, as well as disclose certain information pertaining to such a diagnosis, due to its negative connotations spiritually even more so than physically. This also accounts for the fear felt
in the receiving of such a diagnoses. Such factors contribute towards family's holding out until the last possible moment to seek out of home services. This can in the end make it hard for the elder to bear however because they may suddenly find themselves with a very serious diagnosis and at the same time be removed from the home and community in which they are most comfortable.

The sense of loss of family and community for institutionalized Mexican American elders, having a cultural expectation to be cared for at home, often leaves them with feelings of isolation, rejection, dishonor, and disrespect with regard to their families. A sense of loss of family may also be experienced by the elderly in that finding the appropriate care home to cater to the senior’s needs may not always be in proximity to the individual’s family. Furthermore, a loss of culture when entering an institutionalized facility can be a problem specifically to Mexican American elders as they can immediately experience a loss of familiar surroundings and traditions: a loss of familiar drinks, foods, music, literature, newspapers, and folklore when entering institutionalized care in the United States. Lastly, a loss of community is experienced as they may not always find the comfort of interacting with people from a common heritage as them when they are placed in an institution modeled around the dominant white culture of the US (Maclean & Bonar, 1986). This distancing from family, community, and culture has the risk of exacerbating already serious physical and psychological ailments and makes for an increasingly negative out-of-home care experience.
Another interesting cultural influence was explored in a study conducted by Phillips, Torres de Ardon, Komnenich, Killeen, and Rusinak in 2000 investigating the discrepancies in family care giving between non-Hispanic White (NHW) Americans and Mexican Americans. Results found that Mexican American caregivers utilized less social support and felt less social restriction, and also perceived less change in elder to caregiver family relationships. They also evaluated their performance as caregivers higher than their NHW counterparts, though they had poorer health. Mexican American caregivers were also found most often to be adult children, even when the family member they were providing care for had a living spouse.

There are numerous implications resulting from this study. It was supported that traditionally, Mexican American families expect family members to provide care for elders, particularly the oldest daughter providing care for her parents. It was also shown that Mexican Americans and NHWs view aging and care giving differently and therefore have different expectations. More specifically, Mexican Americans view the aging and care giving process as an opportunity for strengthening of the family relationship and family cohesion. This may account for the study’s finding that Mexican American caregivers were found to evaluate their roles higher, have less desire for termination of the relationship, and had greater satisfaction with their roles than NHW caregivers (Phillips, Torres de Ardon, Komnenich, Killeen, & Rusinak, 2000). It can therefore be deducted that the reason many Mexican American families do not seek out of home care is because they truly feel they do not need it, as opposed to NHW white families which
rate themselves as poorer caregivers suffering greater stress and therefore in far greater need of outside help.

A final significant cultural barrier comes from how many Mexican Americans harbor distrust towards western medicine. Traditional Mexican American values towards healing, such as it being kept within the home, as well as various healing practices being religious or spiritual in nature run counter to the values asserted by western medicine institutions (Espino, et al., 2001). An additional factor contributing towards this distrust manifests in that some Mexican Americans are undocumented and fear that seeking out of home care will result in an investigation that could lead to them being deported (Yarry, Stevens, & McCallum 2007). This fear is often times compounded by these individuals not being able to find adequate information regarding possible services and the process of acquiring them, often due to a failure of information to be provided in Spanish. This leads us to our next section.

Language

Perhaps the preliminary language barrier affecting Mexican Americans’ utilization of elder care services is that materials advertising such services are not translated into Spanish. Even when such materials are offered in Spanish, they are often not done so effectively or in a way that is bi-cultural as well as bi-lingual. Often times simply a raw translation from English to Spanish will result in the overall message of the material being lost (Kao, McHugh, & Travis, 2006). This failure to accurately communicate information regarding possible services coupled with the reticence already
felt by many Mexican American families towards seeking out of home services results in many individuals electing to not even bother reaching out for clarification (Yarry, et al., 2007). For those families which do end up seeking services, other language barriers follow.

Aside from materials advertising care options, there are also a myriad of written materials used during the process of care which are equally important to have competently translated. Ethical issues can arise when individuals do not fully understand various medical forms they may be required to sign before, during, or after treatment. Clients are asked to sign release of information forms for networking between agencies, consent forms to undergo certain procedures or care options, information forms on medical history and past operations and medications, as well as directives for further care options. Additionally, part of the care process may involve the completing of certain information-gathering instruments which are used by professionals to decide the most effective means of treatment to administer. A failure of professionals to effectively construct these materials in additional languages results in their receiving inaccurate information from their clients as well as not their clients' not being able to understand the materials they are signing as clearly as the law dictates necessary for them to give consent (Kao, et al., 2006). These are undoubtedly very significant barriers to seeking and receiving care for Mexican Americans that result simply from a lack of bilingual materials.
Along with language barriers in written materials, there are also significant language barriers in verbal communication between client and care provider. Even those individuals whose first language is English will often find themselves baffled at what their doctors are telling them due to the esoteric nature of majority of medical jargon. Many Mexican Americans, especially elders, do not have English as their first language; some are not even fluent or even close to it. This makes for a huge disconnect in communication. Individuals will find themselves relying on insufficient translation services to relay information to them, many of whom do not fully understand what the doctor is telling them to begin with, much less how to accurate translate it to their clients. It is common for many Mexican Americans to simply feign understanding of what is being told to them in order to avoid embarrassment at appearing unintelligent (Parra & Espino, 1992). Such occurrences make it imperative for institutions to provide bilingual services for their clients.

**Financial**

Many Mexican Americans also face significant financial barriers in seeking out and utilizing out of home care for their elders. Financial barriers involve the fact that nearly 47% of elderly Hispanics are at or below the near poverty level, 30% have no private health insurance, and 19% are not covered by any type of health insurance program. While there are some agencies which take these issues into consideration and offer care accordingly, they are few and far between and can be very difficult for individuals in need to track down (Parra & Espino, 1992). This hails back to issues in
communication and outreach discussed previously, indicating an interactions which occurs among the various barriers to care experienced by Mexican Americans.

While agencies exist which take into account the low socioeconomic status of those in need and plan services accordingly, it can be very difficult for potential clients to find them. Mexican American families in particular face barriers in finding and utilizing such agencies due to the language and cultural barriers discussed in previous sections. This makes it extraordinarily difficult for many Mexican American families to find care which they are able to afford, even if they are able to overcome all of the other trammels listed previously. The combination of all these factors can unfortunately lead to a virtually insurmountable obstacle to receiving services for many Mexican American elders and their families.

**Severity of Ailment**

Bearing all of these barriers in mind, there has been one factor found to be a very reliable predictor of whether or not Mexican American families will seek out of home services: the severity of the elder's ailment. The cultural beliefs towards elder care combined with the language and financial barriers experienced by many Mexican Americans often result in their keeping the care of elders in the home for as long as possible. When such families finally elect to seek out of home care it is often because their family member's impairment has intensified to the point where they feel there is no other alternative (Almendarez, 2007). The financial burden of out of home services, the errors in communication brought about by a lack of bi-lingual staff and materials,
combined with the cultural values of caring for elders within the family seem to all be influenced by the overall need for services necessitated by the severity of the elder's ailment.

To support this point, a study performed by Kemper in 1992 investigated the relationship between such variables as income, availability of family caregivers, and severity of the elder's impairment in families' inclination towards in-home (informal) or out-of-home (formal) services. The study found several significant results. Income was found to have a positive relationship with formal care and a negative one with informal care. This indicates that those families with more money were more likely to seek formal services just as those with less were more likely to seek informal ones. Kemper also determined that the availability of immediate family increased dependence on informal care services and decreased dependence on formal care services. Lastly, the severity of impairment was found to increase need for care across all existing variables.

Several implications can be drawn from these findings. Concordant with previous studies reviewed, Kemper theorizes that poorer families can be expected to have a higher likelihood of seeking informal care than those families of a higher socioeconomic status. Also, those families with numerous available family members are more likely to have elders who seek informal care to formal care. Therefore if a family has a relatively low income and a relatively high number of available family members, an elder from that family will be likely to seek informal care (Kemper, 1992). This shows that the socioeconomic status and availability of family members in Mexican American elders
should be taken into consideration when investigating their selection of formal or informal care, but also exemplifies the influence the nature of an elder’s ailment can have on such a decision.

This phenomenon is no mystery to many Mexican American elders or their families. Despite cultural values oriented around keeping care in the home, many elders are shown to anticipate the increased financial, physical, and emotional strain a severe ailment would have on themselves and their families. This realization is shown to influence the type of services Mexican American elders will feel themselves inclined towards. (Keysor, Desai, & Mutran, 1999). However such a realization does not mean that an elder will forsake their cultural beliefs towards how they should be cared for, nor alleviate any potential feelings of shame on their part or guilt on their family’s part at them being transferred to out-of-home care. There is interplay between the levels of acculturation and the various barriers to care discussed previously which interact with the need for care brought about by the severity of impairment which results in care selected. It is difficult to attribute such a decision to any factor in particular.

A study performed by Mitchell and Krout in 1998 illustrated this point. The effectiveness of predicting the use of discretionary and nondiscretionary services was explored using three different primary characteristics thought to influence choice of health care. The authors defined more discretionary services as various forms of in-home and informal support, and less discretionary services as more formal medical services. It
was asserted services defined along a discretionary continuum could be more accurately predicted by predisposing, enabling, and need characteristics.

Predisposing characteristics refer to those biological, social structural or health belief attributes that may incline someone towards seeking a certain type of care. Enabling characteristics are the factors that allow someone to use a certain service, such as income, insurance, and relationships with others. Lastly, need characteristics are used to describe an individual’s overall health or ability to function: the severity of their ailment. It was found that need characteristics, the level of impairment due to ailment, were the most influential in predicking nondiscretionary, out-of-home, service use. The authors took care to note however that predisposing and enabling characteristics were still found to be reliable predictors (Mitchell & Krout, 1998). So while various barriers to care and levels of acculturation all play a role in Mexican Americans' selection of elder care services, the severity of the ailment experienced by the elder in question is a very influential factor and warrants careful consideration.

**Hospice**

A final relevant factor to the current study focuses on issues around hospice use, a specific type of elder care. Hospice refers to a type of end of life care which focuses on life-affirmation and the recognition of death as a natural part of the life cycle. Hospice does not seek a hastening or a postponement of death, but rather aims to manage its physical, psychosocial, and spiritual symptoms with the goal of maximizing the quality of remaining life and achievement of personal growth and life satisfaction. Hospice
services are designed to be available to all individuals suffering from life-limiting illness, regardless of factors such as age, gender, race, nationality, creed, sexual orientation, disability, diagnosis, availability of primary caregiver, or ability to pay. Hospice is also known for viewing the client as well as the client’s family as the unit of care (Stewart-Rego, 2009). Hospice stands as an often times preferred alternative to hospitalization as a means of end of life care due to the comfort and support it offers clients and their families.

Similar to other forms of institutional care, hospice services are also found to be vastly underutilized by Mexican American elders and their families in comparison to members of the dominant culture. Mexican Americans are the fastest growing ethnic minority in the United States, yet their utilization of hospice care services is among the lowest (Randall & Csikai, 2013). This has been theorized to be due to four primary variables: the high cost of services, bi-lingual and bi-cultural competence of staff and materials, cultural disconnect, and a lack of knowledge towards availability and nature of services, perhaps partly attributable to said lack of bi-lingual materials.

This unawareness of services due to lack of effective communication is thought to be the most influential barrier in Mexican Americans' utilization of hospice. Many Mexican Americans are seen either not knowing such services exist or being uncertain as to what these services actually offer. The disconnect with the translation of "hospice" to the Spanish "hospicio" has been cited, as the word "hospicio" refers to an infirmary and can thus create confusion as to what hospice services actually entail (Stewart-Rego,
This illustrates the effect that insufficient bi-lingual materials can have on potential clients' awareness, understanding, and subsequent utilization of elder care services.

Hospice's effectiveness in regards to client satisfaction has been investigated along the lines of three primary domains of care: physiological, psychosocial, and spiritual. The physical domain pertains to hospice's effectiveness in alleviating physical symptoms to the client's ailment. This refers to the physical end of life comfort sought through hospice. The psychosocial domain goes back to hospice's focus on viewing both the client and their family as the unit of care. This involves the psychological and social support of the client and their family members during the period of transition occurring during end of life care. Issues such as availability of staff as support as well as the networking of other support systems for client and family are covered in the psychosocial domain of care. The spiritual domain is concerned with meeting the client's religious and spiritual needs during their end of life care. Hospice programs offer the services of chaplains and related faith-based practitioners to serve the client and their families (Stewart-Rego, 2009). Client satisfaction in these three domains is often investigated to evaluate hospice programs' effectiveness.

Research performed by Sherra Stewart-Rego in 2009 explored how the physiological, psychosocial, and spiritual domains of hospice were being met for Mexican Americans during their time in the hospice system, as well as identify those aspects of care which clients felt were not being met. This information was then
compiled in order to offer insight as to possible improvements that could be made to serving Mexican Americans in hospice care. Participants reported that their needs in the physiological, psychosocial, and spiritual domains were satisfied overall. In the spiritual domain however, clients stated that their needs were met more by their own spiritual practices and communities rather than those offered by hospice.

The greatest obstacles encountered in utilization of hospice services again went back to the lack of Spanish-speaking help as well as education materials written in Spanish and resulting lack of effective communication between health aides and caregivers as well as clients. Such themes come up time and time again during investigation of hospice usage by Mexican Americans (Randall & Csikai, 2013). It can therefore be seen that the same obstacles which prevent Mexican American families from seeking out of home elder care services also prevent them from seeking hospice services for end of life care. This is unfortunate due to the fact that those individuals who end up utilizing hospice services are found to have quite positive experiences (Stewart-Rego, 2009). Such findings serve to further illustrate the need for financially accessible, culturally competent, and effectively bi-lingual services for Mexican Americans.

**Gaps in the Literature**

There were three gaps found in the literature regarding Mexican Americans and the issues they experience in regards to selecting elder care services. The first gap or limitation within the literature reviewed is that although they were all investigating phenomena pertaining to Mexican Americans, many had to utilize a convenience
sampling method in order to do so (Cagle & Wolff, 2009). This resulted in findings that may not be readily transferable to the general population from the sample measured. Even though the percentage of Mexican American elders is increasing in this country, they still remain a minority (“U.S. Bureau of the Census,” 2010). Many studies expressed remorse in not being able to find larger sample sizes, as well as sample sizes which cover wider geographic areas (Almendarez, 2007). This results in it sometimes being hard to gather an eclectic sample size and therefore have findings which can be reasonably indicative of the overall population.

The second issue within the literature is one that is an unfortunate drawback in many qualitative studies, the danger for reporter bias. Qualitative data analysis relies heavily on both reporter and researcher interpretation of material. There are a myriad of factors which can affect how an individual chooses to report their information, as well as how researchers choose to evaluate that information. Because of the subjective nature of such findings, qualitative studies are often very open to interpretation as to their overall relevance and accuracy towards issues investigated (Salda, et al., 1999). However, some information could not be gathered by any other means than through qualitative methods. So such limitations are often times unavoidable.

The third and final limitation is that many of the studies which involved analyses which compared Mexican Americans to Angle Americans involved comparisons created in an Anglo American culture. This runs the risk of studies resulting in assumptions towards the type of care sought as well as the motivations for seeking such care that may
not carry over to Mexican American culture (Kao & An, 2012). Such assumptions can lead to the overlooking of factors which are very pertinent to Mexican American families but not considered by the dominant Anglo American culture.

One example of this phenomenon was described in the process of assessing a factor such as caregiver burden, the degree of fatigue and stress felt by individuals towards their roles as caregivers. Researchers theorize that many Mexican Americans may be hesitant to admit to feeling burdened in their duties due to cultural expectations for them to be fit and willing to provide care to elders (Jolicoeur & Madden, 2002). Anglo Americans do not share such cultural values and will therefore be more likely to report higher levels of caregiver burden than their Mexican Americans counterparts, whose higher sense of duty may discourage them from making candid reports. A failure to address biases such as this can result in inaccurate information.

Summary

This chapter explored the literature relating to the history of Mexican Americans' selection and utilization of elder care services as well as the primary themes found to influencing this process. These themes included: the process of acculturation, the influences of various cultural, language, and financial barriers, how the existence of specific ailments may influence selection of care, and the effect of hospice services on selection of care. Gaps in the literature reviewed were also investigated. The next chapter will describe the methods used for the current study.
Chapter 3

METHODS

Introduction

This chapter describes the methodology and research design utilized for this project. Details of the methods used in the design of the study, selection of participants, formatting of the interview questionnaire, and data analysis will be provided. The interview process will also be described, as well as the steps taken to ensure the safety and confidentiality of human subjects.

Research Question

The following research question will be the focus of this study: what are the perceptions of providers towards how clients select formal or informal (in-and-out of home) care services for elderly Mexican Americans?

Research Design

A qualitative content analysis approach was used for this study. This exploratory study was guided by Andersen’s Behavioral Model of Health Service Use (Andersen, 1995). Data was analyzed using content analysis with latent and manifest coding methods to evaluate participants’ responses. Detailed descriptions and discussion of each element of the framework for the research design is described below.

Qualitative Approach

A qualitative approach to research is used to allow more flexible methods of data collection. Qualitative data analysis strives for holistic understanding of the information
gathered through presenting feelings in words rather than numbers, producing descriptive data sets based upon spoken or written words as well as observable behaviors (Sherman & Reid, 1994). These methods also attempt to account for the influence of the research setting and process on the findings. This comes in contrast to quantitative data analysis which tends to be more tightly bound by the tenants of modern science, using quantifiable measures of concepts and standardizing the collection of data. This is done through the process of focusing on only pre-selected variables and utilization of statistical methods to look for quantifiable patterns and associations (Hutchison, 2008).

The use of qualitative research has become increasingly prevalent in the social sciences and helping professions. Anthropologists, psychologists, and sociologists have all begun turning to qualitative methods due to its ability to offer a more insight from the analysis of gathered data. Qualitative methods are often defined as identifying either the presence or absence of something and describing its amount in words rather than numbers. This process requires researchers to interpret data in a way different than they would for qualitative studies. Researchers must exercise judgment and choice in the development of different categories, typologies, themes, and classifications of data gathered from more naturalistic situations; meaning situations that are not as controlled or experimental in their structure (Sherman & Reid, 1994). This necessitates a special type of analytic capabilities on the part of the researcher, and can yield a more in-depth understanding of the data collected.
Social work as a practice involves the analysis of clients, policies, systems, and situations in a very comprehensive and open-minded manner. Social workers seek an eclectic gathering of information from different sources in order to truly understand what or whom they are working with. Because of this, social work professionals have turned more and more towards qualitative research methods due to their nature of necessitating more in-depth and comprehensive analysis of data obtained as well as the more naturalistic manner in which it is obtained (Sherman & Reid, 1994). Social workers are able to conduct the kind of research that does not involve them having to reduce factors they are measuring into numerical values, as would be a requisite for quantitative research, but rather put time and consideration into their analysis.

**Exploratory Studies**

Exploratory studies involve the gathering of comparatively small amounts of research material as opposed to more quantitative-based designs. This is often done in those situations where there is a preliminary idea which requires investigation before further elaboration can be accomplished, creating a sort of starting point. More elaborate and specific research can often be conducted following an exploratory study. Exploratory studies can also be helpful in situations where a given practitioner may want to gather information specific for a more finite subject that would be difficult to measure in a wide quantitative population. (Reamer, 1998)
Content Analysis

Content analysis is the systematic method by which researchers are able to create categories and derive themes from the communications used as their means of data collection (Sherman & Reid, 1994). In the case of verbal interviews being conducted for data collection, content analysis would involve the counting of certain words or phrases to assess their prevalence throughout the conversation and identify potential themes and topics. This allows for the creation of a detailed coding system of the communication which has occurred and a subsequent conceptual framework to be formulated (Sherman & Reid, 1994). This process allows for the coding of latent and manifest content. Manifest content are those issues and topics which are directly stated, whereas latent content is the underlying theme which may not be directly addressed (Reamer, 1998). Both latent and manifest methods of content analysis will be utilized for the current study.

Study Population

This study sought to interview professionals working for agencies in the Contra Costa and Sacramento Counties who had direct experience working with the families of Mexican American elders who are pursuing or have interest in pursuing services for the elderly. This includes anything from nursing home staff to care managers in the hospital setting. The aim of this was to gather information from an eclectic array of professional backgrounds on the subject of elder care preferences for Mexican American families. Being that there are numerous different avenues through to receive elder care services,
and a variety of different agencies providing such services, the researches sought to glean information from professionals hailing from as wide a range of agencies and backgrounds as possible. Targeting as inclusive a professional population as this was hoped to yield more comprehensive findings that could be readily applied to the industry of elder care service as a whole.

**Sample Population**

The study was conducted through the interviewing of professionals working with various elder care agencies throughout the Contra Costa and Sacramento counties. Researchers contacted various agencies inquiring as to elder services offered and potential qualifying staff members who would be interested in participating. Following these initial meetings, the study utilized primarily a snowball sampling method to acquire additional participants. The study consisted of 10 participants overall. Snowball sampling refers to the process of gathering additional participants by means of inquiring towards possible subjects from current participants, building upon the existing subject pool (Reamer, 1998). This method was utilized in order to acquire participants likely to have a high level of experience in the desired field, as they were being referred by such professionals.

The greatest strength of the sample population comes from the variety of experiences it offers towards the research. Participants were all from a variety of ethnicities, disciplines, and personal and professional backgrounds. This allowed for a wide range of experiences from which to draw information on the study question.
Having an eclectic gathering of participants has provided a data base which the researchers feel is more readily applicable to the target population as a whole. The greatest weakness of the sample population is its size. Qualitative studies usually have low numbers of participants due to the more in-depth information-gathering process utilized. This allows for more detailed information but also takes more time, resulting in sample sizes smaller than what would be found in Quantitative Research. As is true with any research, a larger number of participants result in a larger data pool which can be more readily applied to predict trends in the target population (Sherman & Reid, 1994). However the strengths offered by a qualitative approach to research outweighed the weakness for the purposes of this study and the researchers were satisfied with the sample population size and data pool gathered.

**Instrumentation**

Data was gathered through interviews guided by standardized open-ended questions. The interview template (See Appendix 2) consisted of 14 open-ended questions as well as 5 demographic questions. This template served to ensure all interviews followed the same structure, but also allowed for open responses to the topics in question. This was done to encourage participants to answer questions as fully and as uniquely as they saw fit, rather than keeping their response confined to shorter, closed-ended questions. Questions were designed to prompt participants to first briefly describe the demographics of their typical clients and to then explore what factors influenced their seeking care as well as utilizing care. The nature of the questions was aimed to prompt
the detail of information required for the planned method of qualitative content analysis of the data required.

Instrumentation was formulated by the researchers for the purpose of this study. No specific reliability or validity tests were conducted, nor were there any pre or post tests. Qualitative studies do not follow the same parameters as quantitative studies, for which reliability and validity tests were initially conceived. Qualitative research does not yield data in the form of charts and statistics as quantitative research does and therefore cannot utilize the same methods, or even require the same methods, for measuring reliability and validity. For qualitative studies, many researchers state that validity cannot occur without reliability and therefore only validity need be investigated. One of the greatest barriers to validity in qualitative research is the danger of bias in the researcher’s interpretation of data gathered (Golafshani, 2003). Baring this in mind, interview questions were designed to yield answers to topic questions which were as complete and self-defining as possible. This made for information on topic areas to not rely on researcher interpretation, ensuring a minimum of researcher bias in uncovering results.

**Data Gathering Procedures**

The researches contacted healthcare provider agencies in the Contra Costa and Sacramento Counties. Information was gathered on the types of services the agencies offered as well as on those individuals within the agency whom worked with Mexican American elders or their families in the selection of care. Contact information on these
individuals was then gathered, and each were given information on the current study and asked if they would be interested in participating. All participants were initially contacted via phone; alternate forms of communication such as email and text messaging were used subsequently depending on the request of specific participants.

Interactions were conducted individually and at a time and place stated as convenient by each participant. Interviews began with an overview of the purpose of the study, information on the researchers, and an explanation and signing of the Consent to Participate as a Research Subject form (See Appendix 1). Both researchers were present for each interview. One researcher would ask questions and explore participants’ answers while the other took detailed notes on the conversation. Interviews lasted from 20 minutes to as long as 1.5 hours, most averaged around 30 minutes. At the end of each interview participants were thanked for their time and asked if they knew any other qualifying professionals who may be interested in participating. Each participant was offered to be sent research findings upon completion of the study.

**Data Analysis**

Notes on each interview were compiled and transcribed into a single document. This document was then looked over by both researchers. Common topics, themes, and sentiments as well as connections and discrepancies between interviews were highlighted and then recorded in a separate document. This separate document was then arranged
into four separate categories found to be the most prevalent themes found across the 10 interviews. These four themes are detailed in Chapter 4.

The development of these four themes was brought about through manifest and latent coding techniques. Key words found throughout the interviews were identified using manifest coding and then highlighted. Latent coding was then used to carefully investigate each passage containing highlighted words and derive the underlying meaning surrounding the target word or phrase. The four common themes were formulated from this process and will be discussed shortly.

Protection of Human Subjects

A Request for Review by the Sacramento State Committee for the Protection of Human Subjects was submitted as required to the Division of Social Work Research Review Committee. After review, the committee approved the study as “Exempt” of risk to the subjects, approval number 13-14-044. No subjects were contacted nor data collected before the approval was received. All participation was voluntary and all professionals interviewed were advised that their participation was voluntary. Researchers also took care to inform participants that they could refuse to answer any of the questions asked, and that they could terminate the interview at any time if they so chose.

Subjects’ names were not recorded in the notes on each interview discussion. The only documentation of participants’ names was on the consent forms, which were kept in a separate folder from interview notes. Interviews were labeled by a number rather than a
name. Participants were also reminded not to use the actual names of any clients which they discussed throughout the course of the interview. All information from the interviews was held as confidential. All subjects were informed of the study’s structure as well as confidentiality protocols. All subjects likewise read and signed the Consent to Participate as a Research subject form. All notes taken on interviews as well as consent forms were destroyed following the completion of research.

Summary

This chapter opened with a reiteration of the research question and design. Information was then provided on the nature of qualitative approach to research, exploratory studies, and content analysis. A review of Andersen’s Behavioral Model of Health Service Use was also provided. The research population was then discussed, as well as the sampling method, instrumentation used, data collection and analysis procedures. Human subjects protections were also discussed. In the next chapter, data analysis will be presented.
Chapter 4

DATA ANALYSIS

Introduction

In this chapter the results of the study will be presented. First, Demographic information on research participants will be provided. Next the four primary themes influencing Mexican American elders’ selection of formal or informal care which were discerned from participants’ responses will be discussed. These themes include issues around language, culture, awareness of services, and finances. The chapter will conclude with a summary of what participants discussed. All participants were given fictitious names to protect their identity.

Participant Demographics

Data was gathered from 10 professionals, 8 female and 2 male, working directly with Mexican American elders and their families. Participants were from backgrounds ranging from the hospital setting, hospice agencies, as well as independent elder care agencies and filled roles ranging from care managers to direct care providers. Specific agencies involved have been left anonymous at the request of several participants for confidentiality reasons. Population includes professionals of varying ages, genders, ethnic backgrounds and range of years in the field of elder care. Levels of professional experience in the field ranged from 8 years to 32 years, education level ranged from Associates of Arts Degree to Clinical Licenses.
Language Issues

Perhaps the most prevalent theme uncovered in the content analysis of data gathered was the existence of significant language issues. Information acquired in the study indicated that most Mexican-American families were hesitant to seek public health services because they could not always find someone who spoke their language. One participant, Victoria stated: “It’s scary enough to go to a new doctor, but it’s even scarier when you know they will probably not be able to understand you: or you them.” Care providers also stated that Mexican-American families may often find their needs lost in translation and, thus, they do not always obtain the appropriate care services required.

Among the Spanish speaking care providers interviewed, one spoke about the high demand for bilingual care providers in her company as she was the only Spanish speaking care manager and therefore the most sought out by Spanish speaking families. This participant, Angelica stated “I am the only one in the agency who can talk to these families. They don’t want to talk to anyone else because they know they will not be understood.” When asked what happened to these families prior to her being at the agency, or what would happen to them if she left, Angelica simply stated “I don’t know.” This demonstrates how agencies who do not have staff members like Angelica will find themselves utterly unable to serve an entire demographic of potential clients. Research performed by Yarry et al. in 2007 confirmed this occurrence in finding that many Mexican American families will elect to not even bother reaching out for services because they know the unlikelihood of their encountering bilingual staff.
Angelica also stated how Hispanic families have expressed feeling more comfortable speaking with her than non-Spanish speaking providers because they felt they could better express their needs and voice their problems without a struggle to communicate “It is more than just speaking Spanish, it is connecting with them and having them feel comfortable with you and trust you. They make you part of the family,” she describes. This supports the importance of a sense of family and community in providing elder care that is so prevalent in Mexican American culture, the importance of which was demonstrated in the study by Espino et al. in 2001 which was reviewed in Chapter 2. Being able to speak with families allows you to build the rapport and trust you need to become a member of their community and be able to administer effective care. Communication is the foundation on which relationships are built.

Mexican-American families are also often found to have difficulties understanding important medical decisions due to doctors’ not being able to speak their language and there being no available translators who can accurately relay such information. Another study participant, Jessica, said “Sometimes it is hard for me to understand what my doctor is telling me, and English is my first language. Imagine it for someone for whom English is not their first language.” This illustrates the point made in the study by Kao et al. (2006) which demonstrated how much information can be lost between patient and doctor when accurate translation services are not available. This loss of information can create discomfort towards asking questions as many Mexican
Americans culturally pride themselves on privacy and distrust those who do not understand their language or cultural values.

This distrust affects access to medical services and the care they provide because it hinders doctors from being able to fully communicate with their patients, who may have a poor understanding of their medical condition and henceforth their ability to cope with their diagnosis. Though there is a federal requirement that virtually all hospitals provide interpreters for non–English speakers, interpreters are often in short supply, if available at all, and will often be insufficient in effectively relaying information to their clients. As one participant, Stephen, explained language barriers in regards to communicating with clients: “It takes more than being bilingual; you have to be bicultural as well.” Communication requires more than just a raw translation of words, there has to be a certain degree of cultural competence to ensure that the overall message of information is not being lost. This point was illustrated by Stewart-Rego (2009) when she demonstrated how often times Mexican Americans will avoid certain services because the Spanish translation of information gives them an inaccurate impression of what services entail. A lack of sufficient communication leads to patients who lack English proficiency to both decline services as well as leave medical appointments without fully understanding doctors’ instructions.

Additionally, something also continuously discussed during data collection was how often times when families act as translators they are uncomfortable translating their relative’s medical condition or simply cannot properly explain the information, thus
creating a poor understanding due to communication barriers. Language itself can also make it difficult to understand the role of a case manager or social worker. Individuals who are not as acculturated may not always have an idea of what a social worker is and can sometimes see them as a threat. For example, Angela stated “It takes a long time to build up trust to the point where a family will work with you. You need to be patient, and willing to meet with them on their terms.” This sentiment demonstrates how the process of communication cannot be a robotic, black and white translation of information, it takes a willingness and ability to really sit down and talk with clients.

One case manager, Alexis, reported that many of her clients feared seeking her services because they feared deportation if she reported their illegal immigrant status. She gives the example: “In our outreach materials the word ‘interview’ is translated to ‘investigación’ which means rather ‘to investigate’, this will scare a lot of people off if they are undocumented.” She reported that she finds herself constantly having to assure families that she is there to help and not take anyone from the home, but actually help them to remain safe in their home longer. This once again supports the need put forth by Kao et al. (2006) for the culturally-sensitive translation of materials.

Cultural Issues

Many different cultural issues were also found to be common themes in the data gathered. The primary cultural issue discussed was that of family values towards elder care. It is common for most Mexican American families to try and keep the care of elders within the home. Elders prefer to be cared for by their children, and their children
likewise prefer to care for them as opposed to seeking outside help. This is consistent with patterns found in the literature review in which the care of elders is said to traditionally fall to the eldest daughter (Espino et al., 2001; Huber & Sandstrom, 2001). The care of elder family members is intended to be a matter which stays within the family.

Feelings of embarrassment and shame among elders as well as guilt among their children are prevalent if care is sought outside the home, and is therefore largely avoided among many Mexican American families. A significant level of dissonance is reported to occur when families find themselves confronted with situations in which out-of-home care is necessitated. This was described by another professional interviewed, Joseph, who said “The children feel they have failed their parents if they seek outside help. It is like they were unable to uphold a duty which they know is expected of them.” These feelings of guilt are the same described by Espino et al. (2001), which the authors described as tending to result from family caregivers who feel that seeking formal care is a sort of surrender or defeat. Because of this it can be hard for these individuals to break their cultural values and seek services, even if they need them.

The participants reported that it often times takes a very significant life event to cause families to break cultural tradition and seek out-of-home services. One participant, Tiffany, said “It usually takes something big for them to reach out, like really intense symptoms that are causing a lot of pain.” Such an event usually entails the progression of an illness that causes significant impairment and affects the individual’s ability to
function as they had previously or results in discomfort which is beyond the abilities of family members to alleviate. This also is consistent with past research on Mexican Americans, which has found the severity of an elder’s illness to be a reliable predictor in their seeking out-of-home services (Kemper, 1992). Participants indicate that clients will frequently hold out as long as possible before seeking services outside the home. Families tend to provide care consistent with their cultural norms and often times will only seek out-of-home assistance as a last resort. This can present a problem however, because as Tiffany went on to elaborate “Sometimes by the time they reach out to us it is already too late for us to do much for them.” Unfortunately, this can lead to Mexican Americans being unsatisfied with services and serve to solidify their distrust and avoidance of formal services in the future.

Another cultural theme that was discussed in interviews but was not prominent in reviewed literature was "machismo". Machismo is a mentality prominent among males in Mexican American culture which delineates the assertiveness, dominance, and paternal responsibility associated with manhood (Cagle & Wolff, 2009). Participants states that this mindset can often lead to male Mexican American elders deciding not to seek formal services because they feel it goes against their masculinity to require extra care beyond what their families can give them. “It usually takes either their spouse or their daughter calling in on their behalf. They feel like it is a sign of weakness,” Jessica described. This can serve to exacerbate the shame felt by elders at having to break cultural tradition and seek outside services. Interviews also indicated that machismo can affect the experience
of those who do end up seeking formal care, specifically in regards to language barriers. Mexican American males will not want to admit they do not understand information read or dictated, and likewise will decline further elaboration in regards to their specific needs due to not wanting to sound as though they are wining or complaining. This can create significant issues in seeking and receiving care.

The next cultural theme discussed was the alternate healing methods utilized by many Mexican Americans. Healing practices in Mexican American culture are far more communal in nature and will often utilize various spiritual or religious elements to the restorative process. Ailments are at times believed to have spiritual causes, such as curses from individuals who wish the person harm or visitations from malicious spirits or occult entities. Such ailments therefore will have spiritual cures or methods of care.

Another participant, Adam, explained: “Certain illnesses are looked at as a kind of curse, so people will turn to god for a cure.” Care of this sort is often administered by religious figures such as priests or by spiritual healers like curanderos. These findings compliment the more detailed information on such cultural healers in past research reviewed in Chapter 2, which emphasized the importance of spirituality in the healing process (Higginbotham et al, 1990; Huber & Sandstrom, 2001). Such healing practices run counter to what is considered the norm in the United States and is therefore very difficult for individuals to find in out-of-home services.

This contradictory nature creates feeling of disconnection, and even feeling of distrust, towards Western Medicine for many Mexican Americans. Adam elaborates:
“Our doctors don’t place much stock in faith when it comes to administering care, most of them it does not even cross their mind. And this widens the gap between western medicine and cultural remedies.” The “gap” between the values of formal elder care institutions and those of traditional Mexican American healing Adam describes here is reminiscent of the disconnect highlighted by Espino et al. in 2001. The researchers noted numerous factors which contributed towards Mexican Americans’ mistrust and resistance towards western medicine, a significant one being a lack of incorporation, or even outright dismissal, of spiritual practices in the care process.

The final, and arguably most significant, cultural barrier affecting Mexican Americans’ utilization of services found during the interviews was the lacking cultural competence of the majority of elder care agencies in the United States. Most agencies reportedly fail to accommodate the cultural needs of Mexican American clients. “It’s the same as the rest of this society: either you make it work for you or you get left behind. There is no compromise. It’s as true with health care is when anything else. It’s hard to find accommodations,” stated another participant, Helen. This is a theme found repeatedly in past literature (Espino et al, 2008; Maclean & Bonar, 1986). Formal care agencies will often have strict service plans which all staff members follow assiduously. This can unfortunately make for a system to rigid to accommodate any individual needing care which differentiates in nature from the agencies norm, such as an individual with alternate culturally expectations towards services.
Care is not generally provided in a way which involves the client’s family, community, or incorporation of religion and spirituality to the level at which it would be expected in Mexican American culture. This absence is found both in the types of services out-of-home agencies offer as well as the staff members present at those agencies. Helen went on to say: “There is no effort to meet in the middle. The thought is: if our agency doesn’t work for you, then get out. And then everyone loses.” This is a raw and unfortunate look at how some agencies operate with their minority clients. Such sentiments make it seem as though it is no wonder Mexican Americans do not seek formal elder care. Clients find themselves in programs that run counter to what they have come to expect in end of life care as well as being cared for by people unaware of these expectations, and sometimes unfortunately unwilling to learn about them. This has the regrettable result of those Mexican Americans who do end up seeking elder care services being unsatisfied with the care provided.

**Awareness of Services**

One of the other primary themes uncovered from participants’ responses was how there is a significant lack of awareness regarding available elder care services among Mexican Americans. This unawareness comes in two primary forms: potential clients either not realizing such services exist in the first place, or clients not fully understanding exactly what these services offer. Victoria stated: “I see a lot of families who only waited so long to reach out because they didn’t know we existed.” This theme was prevalent in past literature as well, which found that often times Mexican Americans do not utilize
services due to their being insufficient accessible outreach informing them of what is available (Kao et al, 2006; Parra & Espino, 1992; Yarry et al, 2007). A lack of awareness of available services is thought to be attributable to several factors. For one, there is a lack of outreach to the Mexican American community. This is perhaps due to the existing cultural factors prevalent in many Mexican American communities around elder care that makes agencies either believe they would not be interested in such services or such agencies being themselves unaware that a high need exists within the demographic.

Next, what outreach does occur is often not bilingual, or at least effectively bilingual. Translation is often times inaccurate or insufficient in actively articulating the services which are being offered. “We have a few pamphlets that will be in Spanish, but in terms of commercials or ads there is nothing. We rely mostly on referrals. The Spanish materials don’t seem to do much other than sit in our waiting rooms. I doubt there is much outreach,” stated Dorotea, another participant, describing the vague nature of outreach to the Mexican American community. Such ambiguity combined with the already existing mistrust towards out-of-home services held by many Mexican American families result in decisions to not pursue such services. Similar findings were discovered by Kao et al. (2007) during their investigation of the effectiveness of translated materials and their effect on client participation in services. Mexican American elders are often already hesitant to even look into out of home services. Such reticence is then exacerbated by materials and individuals who fail to effectively inform potential clients of available services.
This point becomes particularly pertinent in regards to individuals who are undocumented and in fear of deportation. If such individuals are not accurately informed of what out-of-home services entail, they will not seek them simply due to not wanting to risk being exposed as undocumented. For example, recall Alexis’s explanation of the translation of the word “interview” to “investigación”, meaning “to investigate.” This undoubtedly carries a very negative connotation for an individual who is undocumented, causing fear that their participation in services will require an “investigation” which could lead to the discovery of their undocumented status and subsequently to their deportation. For many, this is a risk not worth taking. Fear of this kind combined with uncertainty as to exactly what services are being offered results in many individuals electing to keep their care in the home even if it is no longer practical for them to do so.

Many participants discussed that often times the most effective way for services to be advertised is through word of mouth within Mexican American communities. “The best way to get referrals is to have a satisfied [client] go home and tell their friends and family about the services they received. This lets us get our foot in the door of the community because they are hearing about us from someone they trust,” Jessica explained. One individual who receives and is satisfied with out-of-home services will then tell their friends and family. This allows for the shortcomings of advertising materials to be avoided altogether and works in tandem with Mexican American values towards care giving, rather than against them, by making the community part of process.
Some participants suggested that more intimate outreach campaigns be organized in order to foster the kind of communication which reaches into communities and families to spread awareness of services. The most effective elder care agencies in serving Mexican American families strive hard to get involved within the communities they wish to serve, due to the fact that they are aware of both cultural factors around care as well as possible shortcomings of outreach materials. Alexis related: “We will sometimes reach out to church groups to raise awareness. Especially if we are offering a free clinic which has church sponsors. We always get good turnouts when these events go through, but they aren’t put together often enough.” This demonstrates the effectiveness of such campaigns in reaching out to Mexican American clients, but also shows how often times such efforts are too expensive and time consuming to be done on a larger scale.

A specific care provider that was interviewed who also works with local elder-care help lines expressed the minimal amount of calls being made by Latino families. “[They] won’t call often, and if someone does it is usually the child on behalf of the parent. The parents rarely reach out,” said Victoria in regards to her agency’s effectiveness in networking with the Mexican American community. She reported that Latino families will usually only call in time of crisis, consistent with the findings of Almendarez (2007) which noted that the severity of an elder’s illness or impairment holds a large influence over they and their family’s reaching out for formal care. Victoria
went on to state that once her Mexican American clients do make these calls, they report being very satisfied with and grateful for the help they received from the agency.

**Financial Issues**

Another reoccurring theme found when asking about perceived barriers to care for Mexican-American families were financial issues. Stephen confided: “A lot of our families live paycheck to paycheck; any irregularity in their expenses can be devastating to their financial situation. They can’t afford to get professional care.” This illustrates the fact that long-term care can be very expensive and often times only affordable for those with long-term care insurance, retirement benefits from their employers, or those who have saved enough money for future care needs. However, as was demonstrated by Parra and Espino (1992) almost half of Mexican Americans live at or below the poverty level, and close to 20% of them are not covered by any type of health insurance. This makes the high cost of services a serious issue for Mexican Americans seeking formal care. For many, the only hope is to either have private insurance, insurance form their employment, or enough funds to pay the expenses themselves.

Unfortunately, many Mexican Americans do not always fit into any of these categories as they may often times be undocumented or employed in low-paid blue collar jobs that do not provide any form of retirement benefits or insurance. The large proportions of poor elderly Mexican Americans are without health insurance benefits. This places this ethnic subgroup at high risk for not receiving any health maintenance care, or urgent medical attention (Parra & Espino, 1992). For example, Stephen reported
that many Mexican-American families often express living pay check to pay check due to the limited jobs available for them without a college education or English fluency, which hinders them from saving for future care even if they wished to. As consistent with the literature review, out-of-pocket expenses for hospitalizations, outpatient clinic visits, and prescription medications deter elderly individuals from receiving adequate medical care (Parra & Espino, 1992). Potential clients have insufficient resources at their disposal to cover the expense of care.

An additional factor unveiled in research when speaking about financial issues was that the culture itself does not prepare for those finances. Mexican-American families may not customarily save for long-term care since they often rely on their family to care for them. In traditional Mexican-American families it is usually the oldest daughter’s responsibility to care for the aging parents. Joseph emphasized how common it is for Mexican-American families to care for their own: “Elder care is not something included in their financial planning, it’s intended to be kept within the family. In which case, there is no need to save up for it.” This statement illuminates an important intersection between the themes of culture and financial situation.

Mexican Americans harbor a large amount of respect for their elders. A term identified as “familismo” is instilled in the culture at a very young age. Familismo can be described as the importance of the extended family in decision making, particularly when discussing serious medical conditions. The young are expected to value their family obligations and to share in the care taking, financial responsibility, emotional support,
and problem solving that arise from the values of familismo (Almendares, 2007). As a result, often times the financial obligations of the elders’ care may fall on the adult children or extended family, as it is instilled in the culture that families must take care of their own in any way needed. This serves to further Joseph’s point, families do not plan on having to save up for out-of-home services.

Jessica offered additional insight on this theme in sharing how most of her Mexican-American clients often go through other channels before contacting for help with services. She stated how families troubled with financial issues will resort to cultural networks first such as members in their extended family, friends, or church members and will only approach her when they are in a crisis stage seeking immediate help. “[They] will exhaust every other option before coming to us out of fear of the cost. The problem is, the more the wait the higher the end cost will pile up,” Jessica explained. This turns into another financial issue itself as costs become higher with the higher level of care needed that could have been avoided through preventative care.

**Summary**

In this chapter, data from the study was analyzed and discussed. The following chapter will offer a description of the conclusions, recommendation, and limitations of the study and will discuss possible implications for social work practice and policy.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter will discuss the conclusions reached in the study and their ramifications. A summary of the study will be provided in which the relationship between the primary themes uncovered throughout the literature will be discussed, as well as the influence of these themes on the field of elder care as it pertains to Mexican Americans. An overview of recommendations set forth in accordance with the study’s results will then be explored. Next an identification of possible limitations within the study will be discussed, followed by an outlining of possible implications from the study.

Conclusions

This study sought an exploration of the question: What are the perceptions of providers towards how clients select formal or informal care services for elderly Mexican Americans? Four primary factors were uncovered through investigations of professional perceptions on this decision making process: the influence of language issues, cultural issues, the issue of potential clients’ awareness of services, and issues around finances.

Language barriers were discovered to have a huge influence on Mexican American families’ selection of elder care services. Data found that the vast majority of staff members at formal elder care agencies do not speak Spanish. This becomes a serious issue when many elderly Mexican Americans have limited English skills. A huge disconnect develops between client and staff as a result of such a language barrier.
Clients and their families find themselves dealing with staff personnel who are unable to fully understand their needs, and with whom they are unable to fully articulate them. This language gap is found not only in oral communication, but on written materials as well. Medical charts can be hard enough to decipher when being read in one’s first language. Clients are often unable to fully understand their situation, or even ask for clarification because of this.

This is not the first study to find language to be a deciding factor in Mexican Americans’ selection of elder care services. Review of the literature discussed research conducted by Kao et al. in 2006 which focused on the effectiveness of written medical materials utilized in elder care services. It was found that more often than not such materials were not translated into Spanish. When they were translated, it was often done so in an insufficient manner. This resulted in many Mexican American elders being unable to understand what they were reading and subsequently be unable to accurately act on or respond to it. This results in clients not understanding what services they are receiving or could receive, and leads to their either discontinuing services, declining to follow up on service, or avoid such service in the future. This trend was prevalent in information from the current study as well.

The language issues found in data gathered are also seen to effect Mexican Americans’ selection of care on a personal level rather than merely a communicative one. Participants described that many Mexican American clients will be embarrassed to admit that language is a barrier towards their seeking or receiving care. The term “machismo”
came up several times, a word that refers to the type of masculine thoughts and behaviors adopted by many Mexican American males. This mentality results in many Mexican American men not wanting to appear weak by admitting they do not understand something they are told or read, and may even prevent them from agreeing to seek care in the first place. This is the same reluctance to admit to language difficulties described by Parra and Espino (1998) in which they found many Mexican American patients to feign understanding of what they were told or read in order to avoid feelings of embarrassment.

Along with these language issues, there were also numerous cultural issues found to be responsible for the decision making process of Mexican American elders and their families. Cultural beliefs towards elder care were found to have a huge effect on the types of services Mexican Americans pursue as well as when they will reach out for them. Participants were unanimous in saying that it is traditional for elders to be cared for by their eldest daughter or daughter in law. Furthermore, elder care is meant to be kept within the family with elders staying with their primary care providing family member in their old age. Because of such values Mexican American families will often be very hesitant to seek formal elder services. A similar pattern was found in numerous other studies investigating the role of culture on care preferences (Clark & Hutlinger, 1998; Espino et al., 2001). Elders are likely to experience shame at not being cared for by their family as is culturally expected, and family members will feel guilty that they were unable to carry out what they feel is their duty. This reticence to seek formal care is reported to play a huge role in Mexican American families’ selection of elder care.
Participants also reported that clients’ cultural perceptions towards health care were a significant predictor of their preferences for services. Many Mexican Americans harbor a distrust of western medicine due to its core values and practices running somewhat contradictory to their own cultural beliefs. This was also found to be true in the study by Espino et al. in 2001 which was described in the literature review, where the researchers found many Mexican Americans to avoid formal elder care services due to culturally held distrust of western medicinal institutions. Data from the current study revealed that many clients are accustomed to having care for illnesses that is based strongly in their community and religion, and which involve folk remedies not available in formal institutions. Participants reported that for Mexican American elders to seek formal it either takes a severe turn for the worse in an elder’s health, similar to what was reported by Espino et al. in 2008, or a specific recommendation from a trusted family or friend in the community due to these reasons. Interviews also indicated that the affects of language and culture on Mexican Americans’ selection of care is also compounded by the fact that the vast majority of staff personnel are not bilingual or culturally competent.

Financial issues were another significant predictor of care selection uncovered during the interviews. The literature review described a study which listed relevant statistics on the financial standing of many Mexican American families and proposed this to be a reliable predictor of care selection (Parra & Espino, 1992). The current study found this to be the case as well. Participants explained that many of their clients avoided services due to financial complications. Many formal elder care services are
extremely expensive, which results in individuals without significant resources being unable to utilize them. There are those agencies out there which cater to those individuals who struggle financially but they can be difficult to find and even more difficult to get accepted. It becomes even more difficult for Mexican Americans to find such agencies due to the cultural and language issues described previously.

Lastly, interviews indicated that Mexican Americans’ unawareness of available services is a significant predictor of their utilization of such services. These findings compliment those of Stewart-Rego’s 2009 study on hospice usage reviewed in Chapter 2. Participants in the current study described that many of their clients reported having been unaware of what services were available to them. Often times it took them being told of services by a family friend due to the lack of competent outreach to the Mexican American community. Even when potential clients are aware of services, they often do not fully understand what such services entail. This can be compounded by the language barriers and cultural issues described previously.

While language issues, cultural issues, financial issues, and issues related to awareness of services are four separate themes which were discovered to influence formal or informal elder care selection for Mexican Americans in this study, it is also important to note the interplay of these themes between one another. The cultural disconnect and mistrust felt towards formal care agencies by many Mexican Americans is perpetuated and exacerbated by the poor communication engendered through services not being effectively bilingual. It is possible that this disconnect could be overcome if
potential clients were better informed of the nature of available services, but the combination of existing language barriers and a lack of effective outreach results in this never occurring. Likewise, the hesitation due to finances could be alleviated by knowledge on low-income services and considerations. However this knowledge is rarely gained to the cultural and lingual barriers which lead to unawareness of these services. The factors which determine Mexican Americans’ selection of elder care services are multi-faceted and interdependent, necessitating a multi-faceted and interdependent solution.

**Recommendations**

This study makes recommendations in three areas: future research, individual elder care practice, and elder care agency policies. These recommendations are presented below.

**Future Research**

Findings in our study suggest a definite need for more research to be conducted in regards to Mexican American elders' and their families' decision making towards elder care services. Given the fact that most Mexican American elders are cared for at home by family, relatively little is known about Mexican American families' approaches to long-term elder care services. Awareness of this is important to social work research as the Mexican American population is becoming the largest and fastest growing ethnic minority in the United States.
Furthermore, given the small sample sizes of the research studies used for this study’s literature review, there is a need for future research to be conducted with larger Mexican American samples to provide more generalizable results. Many larger studies conducted on elder care fail to mention the Mexican American population which makes it difficult to understand their unique needs and perceptions in regards to formal and informal elder care.

**Individual Elder Care Practice**

Findings also offer several recommendations for individual elder care practitioners in regards to Mexican American elders’ dealing with the difficulties that can arise when choosing long-term care. Such recommendations are relevant and important to social work practitioners as well as those in the public service arena as our elder population increases not only in size but also in ethnic diversity. With the baby boomer generation turning 65 or over in the next decade, more ethnic elderly people will become involved with the social service system (“Administration on Aging,” 2011). This will increase the need for social service workers to be culturally competent and prepared to work with ethnically sensitive issues.

The study recommends that practitioners seek an enhanced awareness of the cultural attitudes and beliefs of Mexican Americans through personal education and outreach in order to obtain a better understanding of their approaches to long-term care. The successful implementation of effective cultural competency is crucial to our society in order to better assess and comprehend the needs of all families served (Kao et al.,
The study also recommends a higher focus on Mexican Americans’ family system and at-home communities in order to provide more effective outreach as well as more effective care. Care providers need to view the family as a whole as their client, rather than just the individual seeking care. This will serve to work alongside the cultural values of Mexican Americans rather than against them. This recommendation however is intended to extend even beyond individual practitioners and into the policies of elder care agencies.

**Elder Care Agency Policies**

From the findings of this study, it is recommended that elder care agencies implement greater community outreach to the Mexican American population. As found in the study, many Mexican American families are often uneducated about the services available or in fear of receiving assistance from the government due to their immigration status. Advocating for this marginalized group will serve to assist in getting more families the services they need, which in the long-run can prevent further crises. Effective community outreach and education will help Mexican Americans learn what services are available to them as well as dispel any inaccurate perceptions towards such agencies that may deter them from seeking services.

An integral element of this outreach is the need for agencies to develop adequate bilingual materials and acquire an adequate number of bilingual, and bicultural, staff members. This ensures that Mexican American families will be able to fully comprehend the nature of the care services available to them and therefore be able to make more
informed decisions about such care. From the study results, we strongly encourage all elder care agencies to work hard in rendering their bilingual services in order to effectively reach out to the Mexican American community. Agencies that have bilingual staff will be able to provide more effective care to those Mexican American clients who are already utilizing their services.

**Limitations**

This study had several limitations. The discussion and recognition of these limitations will help to better define this study and its possible shortcomings, but also provide a starting point for future research and inquiry.

Perhaps the most significant limitation of this study was the disadvantage of using a qualitative research approach. Issues associated with this method of data collection include the essentially subjective nature and lack of generalizability. Another limitation that can arise with qualitative research is the inclusion of the researchers’ personal biases. Critics of qualitative research have argued that the qualitative approach can be rather subjective and biased in large part because the researcher is the instrument of both data collection and data interpretation (Sherman & Reid, 1994). Additionally, the researchers’ biases are also at risk of being communicated to the research participants during an in-person interview. When compared to other data collection techniques, the researcher’s presence during qualitative data collection can potentially pose a threat to results as it can affect the subjects’ responses, also known as the interviewer effect (Golafshani, 2003). Lastly, another limitation posed by qualitative content analysis is the possibility that the
meanings of the words used by the participants are open to the researcher’s own interpretation thus creating a threat in validity.

Furthermore, due to the small sample size and its subjective nature, qualitative research it is not generalizable to large populations. A limitation specifically applicable to this study was that the data was collected from a secondary source. Due to data not being collected from the elders’ families directly, we have to trust that the care providers’ knowledge of the families’ analyzed are precise and feasible. This can affect the data findings, overall, due to the possibility that the family may have had other factors affecting their decision making process in which the care provider was not aware.

**Implications for Social Work Practice and Policy**

The implications of this study will benefit the distribution and management of elder care to the Mexican American community on the micro, mezzo and macro levels. On the micro level, individual caregivers who participate in this study will benefit from the self-reflection engendered by their discussion of what factors expedite and trammel the care they provide to Mexican Americans. These care givers’ agencies and clients will likely also benefit from their evaluation of the services they provide, as it offers insight as to what practices are effective, and why, and what ones could use improvement. Participation in this study will also stimulate participants to have discussions of a similar nature with other professionals in the field of elder care, and therefore further spread the knowledge participants gained through their self-reflection.
On the mezzo level, elder care agencies involved in the study by way of the participation of their employees will benefit from the increased self-awareness and critique of existing services brought about through participants’ examination of their own practice. Other employees within these agencies will benefit from the discussions that will likely arise as a result of participants’ involvement in the study, and be able to learn more effective means by which to serve the Mexican American community from the experience as well. Agencies will also be able to evaluate their existing services and policies in light of the study’s findings and strive to increase their efficacy.

Lastly, on the macro level elder care services as a practice can benefit from the study. Findings stress the need for the United States’ social and health policy structures to reform in order to adapt to the needs of the rapidly growing elder population. As stated previously, many of the Mexican-American elders are often found to be uninsured or undocumented and sometimes suffering critical illnesses. Thus, the demand for availability of affordable health care services will continue to increase and a reform for long-term care policies in order to accommodate to these needs at a reasonable cost will be necessitated. Elder care agency’s awareness of these issues will increase the push for policies which will strive to alleviate or at least attenuate them.

**Conclusion**

The purpose of this study was to investigate the factors which contribute towards Mexican Americans' selection of formal or informal services in caring for their elders. The study sought to accomplish this by gathering the perceptions of professionals who
work directly with Mexican American elders and their families during the care giving process in regards to what they believed such factors to be. The study found three significant themes to exist in influencing Mexican Americans' selection of formal or informal elder care: issues around language, culture, awareness of services, and finances. These themes act independently as well as interact with one another to exact effects on Mexican Americans' selection and utilization of elder care services. Researchers suggest greater cultural and bilingual competence among the staff and material of formal institutions, greater outreach to the Mexican American community by these institutions, as well as the development of policies to provide ensure such developments as well as provide affordable options of formal care to those struggling financially.
APPENDIX A

Interview Guidelines

1: Describe the age and gender of the client and their close family.

2: How long have you known the client(s)?

3: Who contacted you for care of the client?

4: Who was client’s primary caregiver prior to their referral to you?

5: How would you describe your professional relationship with the client?

6: How would you describe your professional relationship with the client’s family?

7: What factors contributed towards your client’s selection of elder care services?

8: What made your client choose out of home care?

9: What made your client not choose out of home care?

10: Do they seem satisfied with care?

11: Have you perceived any cultural barriers to exist in providing service?

12: Have you perceived any cultural barrier with clients utilizing services?

13: Have you perceived any language barriers to exist in providing service?

14: Have you perceived any language barriers with clients utilizing services?

15: Demographics of Providers:

   1) What is your area of professional experience?
   2) How long have you been in the field?
   3) What is your gender?
   4) What is your highest degree completed?
   5) What is your ethnic background?
APPENDIX B

Consent to Participate in Research

You are invited to participate in a research study that will be conducted by Lizette Rocha, and Michael White, graduate students in the Division of Social Work at California State University, Sacramento. This study will explore the perceptions of providers towards how clients select in-and-out of home care services for Mexican American elders of themselves and their families.

Procedures

After you have read, agreed and signed this consent form to participate in this study, the researcher will conduct an interview with you utilizing a pre-designed questionnaire. The interview will last approximately 30 minutes and will consist of questions regarding your perceptions of how clients select elder services for in-and-out of home care services. At the end of the interview, the researchers will ask you to refer up to three referrals of providers that may be interested in participating in this study. The interview will be recorded. After the recording is transcribed, the recording will be deleted. All recordings will be deleted by August 31, 2014.

Risks

There are no known risks to participating in this study. Your identity and the agency you are employed through will be kept confidential and not included in the findings of this study. In place of your identity, a pseudo name will be used.

Benefits

The benefits of participating in this study may include contributing to the knowledge and data gathering of services in the community of Contra Costa County. Through participation, the information provided will be gathered and evaluated, and perhaps will lead to new services or programs to better serve families in the community.

Confidentiality

All personal information gathered will be kept confidential and not utilized in the study findings. In an effort to maintain confidentiality, recordings will be deleted following being transcribed and all hand-written notes will be destroyed by August 31, 2014. All the research gathered will be stored in a locked drawer in the researcher’s home. Further, a pseudo name will be used in place of your identity.

Compensation

There is no compensation being offered for your participation in this study.
**Voluntary participation**

Participation in this study is completely voluntary and you can withdraw at any point. If there are questions you prefer not to respond to, please inform the researcher and she will move forward to the next question.

I, ________________, agree to be recorded for interviewing purposes of this study.

I, ________________, agree to participate in the above mentioned research study.

Signature: _____________________________    Date:_______________________

If you have any questions you may contact one of the researchers, Lizette Rocha at XXXXXXXX89@yahoo.com or Michael White at XXXXXXXX22@gmail.com.

Or, if you need further information, you may contact the researchers’ thesis advisor: Maria Dinis, Ph.D., MSW
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REFERENCES


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