ATTITUDES ABOUT CAREGIVING: AN ETHNICITY BY GENERATION APPROACH

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Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2016

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Caballero, Daniela Maria. <u>Attitudes about caregiving: An ethnicity by generation</u> <u>approach.</u> Doctor of Philosophy (Clinical Psychology), August 2016, 96 pp., 20 tables, references, 92 titles.

The goal of this project was to understand ethnic and generational differences in attitudes towards caregiving and expected burden while taking into consideration factors such as gender, generation, familism, and acculturation. One hundred and sixteen young adults (ages 18-25) and 93 middle-age adults (ages 38-62) were enrolled in the study. Participants included European Americans, African Americans, and Hispanics. Using moderation analysis, two hypotheses were investigated: 1) Ethnicity relates to attitudes towards caregiving, moderated by gender, generation, familism, and acculturation. 2) Ethnicity and expected burden relate to each other, moderated by gender, generation, familism, and acculturation. Familism emerged as a moderator in the relationship between ethnicity and expected burden. Results suggested that the strength of the relationship between being African American and expecting burden was less for those with moderate familism ($R = .078$), slightly higher for low familism ($R = .176$), and the highest for high familism ($R = .261$). Additional results indicated that the strength of the relationship between being Hispanic, as opposed to being European American, and expected burden, was higher for middle-aged adults ($R = .23$) when compared to young adults ($R = .19$). The current findings lend support to the recently established idea that familism is not protective against burden as it increases one's sense of obligation towards family (Knight & Sayegh, 2010).

ACKNOWLEDGMENTS

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CHAPTER 1

Introduction

The last U.S. census (2010) demonstrated marked shifts in the development of the total population of the United States. Of primary interest is that over a period of 10 years, people 65 years and over increased at a faster rate (15.1 percent) than the total U.S. population (9.7 percent), with the 85 to 94 year-old group experiencing the fastest growth, increasing from 3.9 million to 5.1 million. With improvements in health care and diet, individuals are living longer; thus, the same census has estimated that by 2050, the 85+ population will triple. Unfortunately, as life expectancy increases, the risk of contracting illnesses like cancer, dementia, and stroke also increases.

Of equal interest is the vast increase in ethnic variability in the United States. The 2010 U.S. Census demonstrated that most of the growth in the total population came from increases in minority populations. Over the last decade, the Hispanic population grew by 43 percent, rising to 16 percent and accounting for more than half of the increase in the total population. It has been estimated that by 2050 Hispanics ages 65 and older will increase from 6% to 18% (Federal Interagency Forum on Aging Related Statistics, 2006). Mexican Americans are of particular interest because they make up almost 50% of older Hispanic adults in the United States (Angel & Whitfield, 2007).

The anticipated growth of both groups emphasizes the need for research among these two populations. With the Baby Boomers turning 65 over the next decade and life expectancy increasing, as well as the population of ethnic/racial minority individuals surging, it becomes increasingly important to understand the implications these two growing populations have for family, social, and economic aspects of society (U.S. Census Bureau, 2011). Similarly, with an

increasing proportion of older adults and the stability of birth rate, understanding the dynamics

of caregiving can aid in education for public officials, policy makers, and the community-at-

large regarding the needs of caregivers from diverse groups.

Formal and Informal Caregiving

The current economic downturn coupled with policy changes surrounding Social

Security, Medicare, and Medicaid Services highlight the issues surrounding formal and informal

caregiving. Family members of a relative in need of care are left with the task to choose between

formal and informal care based on how much they can depend on publicly funded programs,

their income, and their relative's savings. In general, formal caregiving is defined by professional

care provided either in an institutional setting or at home by doctors, nurses, and other healthcare

personnel. Informal caregiving, on the other hand, is provided by family members or friends at

home. Informal caregivers can be middle-aged adults who are in the middle of raising families,

holding full-time jobs, and caring for their aging parents. Informal caregivers can also be college

students in their early twenties, providing care for parents or grandparents. Yet another type of

informal caregiver can be an older adult, taking care of a chronically ill spouse. Similarly, care

receivers can be individuals of all ages who experience chronic illness, disability, trauma, and/or

cognitive impairment. Informal caregivers may provide assistance with daily activities such as

eating, bathing, dressing, shopping, transportation, etc.

Based on estimates by Rogers and Komisar (2003), approximately 10 million Americans

needed long-term care in 2000. That number was estimated to increase to 27 million by 2050 as a

result of the growth in the population of older adults (U.S. Department of Health and Human

Services, 2003). Taking into consideration only informal caregivers, approximately 52 million

Americans provide care for family or friends of all ages with severe disabilities well into retirement (Takamura & Williams, 1997).

The primary caregiver.

Most often, one individual within the family is considered the primary caregiver for the care receiver, while other family members and friends provide secondary care. Montgomery, Rowe, and Koslosky (2007) suggest a hierarchy in the selection of primary caregivers. This hierarchy takes into consideration sex, generation, and geographical location. They propose that the first in line to assume the care of a disabled individual is the spouse. When a spouse is not available, a daughter is the next one in line. Sex is an important determinant of who will provide care, because if there is not a daughter that can provide care, the responsibility will fall into the hands of a daughter-in-law before it falls into the hands of a son. If the individual in need of care does not have any adult children, then the responsibility falls on other relatives. Geographical location is another important factor in determining who takes on the responsibility of primary care. Usually, the adult child who lives closest is the one to take on the responsibility, with those adult children who do not live in the area providing other sources of help, such as financial assistance.

Caregiving as a Process and as a Career

Montgomery et al. (2007) refers to caregiving as a dynamic change process. Some of the things that change in this process include care activities, the relationship between the caregiver and care receiver, and ultimately the caregiver's identity.

Montgomery and colleagues suggest that the caregiving role develops from a familial relationship between care receiver and spouse, daughter, or son. The familial relationship changes solely to a caregiving relationship as the needs of the care receiver increase in quantity and intensity over time or the course of the illness; as the familial relationship changes, the identity of the spouse, daughter, or son changes as well. The identity of the family member changes because of a discrepancy between the initial role of the family member and the needs of the care receiver. Thus the family member's identity changes from a familial identity to a caregiver identity as the care receiver becomes more and more dependent on that family member.

The care provided by caregivers varies greatly. The quantity and type of care provided changes as the care receiver's health worsens. For instance, with regards to quantity, some older adults whose cognitive functioning is normal only receive 4.6 hours a week of informal care. On the other hand, older adults with severe cognitive impairment receive more than 41.5 hours a week of informal care (Langa et al., 2001). The type of care provided changes as well. For those individuals that need to be cared for 4.6 hours a week the caregiver's responsibilities include helping pay for bills or transportation, while the caregiver responsibilities for those with severe cognitive impairment include those of bathing and preparing meals. These differences in quantity and type of caregiving, lead to significant differences in amount of stress for the caregiver.

Most of the time, for caregivers of a relative with a progressive, debilitating disease, the change in role identity is slow. At first, the caregiver may help the care receiver with small tasks that only require a minimal extension of the familial role. These tasks may include helping the care receiver pay for bills or transporting them to and from appointments. However, as the disease progresses, the needs of the care receiver increase, placing more demand and more stress

on the caregiver. Ultimately, discrepancy develops between what the caregiver has internalized as to the help he or she should provide to spouse, mother, or father and the actual needs of the care receiver. Therefore, the caregiver, instead of being a spouse, daughter, or son to the care receiver assumes a "caregiver" identity and the relationship changes from a familial relationship to a caregiving relationship (Montgomery et al., 2007).

Researchers have used the term "career" as a way of describing the lengthy process of caregiving (Pearlin et al., 1992). Identifying the onset of caregiving is not easy since most of the time it is unexpected. Five phases of the caregiving career have been identified by Montgomery and colleagues (Montgomery, et al., 2007; Montgomery & Kosloski, 2009; Montgomery & Kosloski, 2013). Phase I indicates the onset of caregiving. Movement along the different phases happens as the needs of the care receiver progress and the caregiver's identity shifts from the familial role to the caregiver role. Phase V begins with the placement of the care receiver in a nursing home facility and the caregiver gains some of his or her familial role identity back. Most of the stress that caregivers experience occurs when they notice the discrepancy between their familial role and caregiver role. For instance, the stress sets in when a daughter has to bathe her mother on a daily basis. This stress is what prompts caregivers to seek other sources of informal or formal support. For these sources of support to successfully help the informal caregiver, they need to diminish the discrepancy between the familial role and caregiver role the informal caregiver is experiencing (Montgomery et al., 2007).

The ultimate outcome of the caregiver career and process is grief and bereavement. Grief and bereavement refer to those reactions individuals have to a major loss. These reactions are most often characterized by feelings of sadness and emotional pain. In the caregiving relationship, sometimes the primary caregiver and the people close to the care receiver

experience anticipatory grief. Family members and friends may experience conflicting emotions, such as fearing the death of the loved one, while at the same time hoping for closure and an end to the care receiver's and their suffering. Other conflicting feelings include anger towards the loved one for the burden they experience as a caregiver and guilt at the same time for having experienced that anger. Furthermore, family members and friends may feel burdened and experience physical and emotional exhaustion while waiting for their loved one's death (Singg, 2009).

Experiencing anticipatory grief does not necessarily mean that the caregiver expects their relative's death and has an easier time grieving. As a matter of fact, many caregivers consider the death of their loved one very unexpected. Unfortunately, this lack of expectation can lead to more depression and complicate grief experienced by the caregiver. Caregiving can have a long-lasting effect. Research has found similar depression levels in former caregivers when compared to active caregivers, even years after they became former caregivers (Bodnar & Kiecolt-Glaser, 1994).

Theoretical Frameworks to Understand Caregiving Distress

To understand the distress experienced by caregivers, researchers use three different theoretical frameworks. Extracted from Knight's 2010 article, the three models that are predominantly used include the stress and coping model (Lazarus & Folkman, 1984), the stress process model (Pearlin, Mullan, Semple, & Skaff, 1990), and the diathesis-stress model (Gatz, Kasl-Godley, & Karel, 1996). Keeping in mind caregiving, the stress and coping model highlights the appraisal of caregiving as a stressor that leads to burden. The stress process model highlights the difficulties caregivers experience when caregiving gets in the way of their other

responsibilities, with work or family for instance. The diathesis-stress model includes the caregiver's biological vulnerabilities that put her or him at increased risk for illness when undergoing the stress of caregiving.

With the marked increase in minority populations, taking into consideration cultural variables enhances our knowledge of caregiving. Knight and Sayegh (2010) updated Lazarus and Folkman's (1984) stress and coping model in their sociocultural stress and coping model, which uniquely included a sociocultural component. They proposed a commonality exists across different cultures in that a care receiver's disruptive behaviors lead to burden, and burden leads to depression and anxiety. However, culture determines how other factors play a part in this model and moderate the impact on depression and anxiety. In this updated model, they propose that cultural values operate through coping style and social support and ultimately affect depression and anxiety. For instance, the cultural value of familism may be expected to operate through the amount of social support a primary caregiver receives from family members and friends.

For the purpose of this dissertation, the stress and coping model was followed by highlighting the appraisal of caregiving as a stressor that ultimately leads to burden, while taking into consideration variables that may moderate this relationship.

The Impact of Caregiving

Providing long-term care for a relative is a responsibility that approximately 80% of Americans face in their lifetime (Montgomery et al., 2007). As the older population increases, more older adults are being cared for at home by their adult children. Caregiving can last for decades and take a substantial amount of time - up to 27.4 hours per week (Brouwer, Van Exel,

van de Berg, Dinant, Koopmanschap, & van den Bos, 2004). Informal caregiving can be

rewarding and satisfying, leading to positive outcomes, but it can also bring negative outcomes

such as emotional, physical, and financial burden. The relationship between the caregiver and

care receiver may influence the impact of caregiving and whether caregiving leads to positive or

negative outcomes for the caregiver and the care receiver.

Factors impacting caregiver stress.

The stress and coping model allows us to understand caregiver stress and burden as the

result of a compilation of factors that influence the appraisal of caregiving. The factors can be

differentiated as care receiver and caregiver variables that have an effect on the appraisal of

caregiving.

Some variables that have been found to be associated with caregiver stress include the

care receiver's cognitive status, disruptive behaviors, physical demands, increased need for

assistance, and their particular illness (Montgomery et al., 2007). The care receiver's disruptive

behaviors and increased need for assistance decrease the amount of time the caregiver has to

engage in their own hobbies and social activities. Other care receiver's difficulties, such as

illnesses as a result of older adulthood, may also have a great impact on the caregiver.

Caregivers' physical and psychological well-being has been found to be highly correlated to the

well-being of the care receiver (i.e. poorer health in the care receiver increases stress in the

caregiver). For instance, Brouwer et al. (2004) found that caregivers of a spouse or significant

other with mild to moderate rheumatoid arthritis (RA) are relatively healthy; however, those with

a spouse or significant other with severe RA indicated being relatively unhealthy. Often, the

impact on caregivers is as troublesome as the care receivers' difficulties. Furthermore, low levels

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of support and minimal help from family members (Biegel & Blum, 1990; Montgomery, 1992) have a synergistic effect on the stress experienced by caregivers.

Caregiver variables that relate to stress levels include demographic factors such as age, gender, education, and income. A multinational review of North American samples suggested that in general, being young, a female, and having low education and low income are characteristics that make someone more vulnerable to caregiving burden (Torti, Gwyther, Reed, Friedman, & Schulman, 2004). Similar results have been found in individuals of different countries. For instance, Papastavrou, Kalokerinou, Papacostas, Tsangari, and Sourtzi (2007) found among individuals from Cyprus that being a female and having lower education and lower income are factors related to burden. In general, it appears as if being an older male with higher socioeconomic status are factors that may function as buffers to the stress of caregiving. Additionally, social support to the caregiver may mediate the stress that the caregiver experiences (Haley, Levine, Brown, & Bartolucci, 1987). Haley and colleagues found that amongst caregivers of moderately to severely impaired elderly patients with dementia, caregiver outcomes such as depression were not due to the severity of the stressors they were living under, but to the caregivers' appraisal of their relative's problems, their self-efficacy, and social support. Furthermore, they found that caregivers with large support networks reported higher life satisfaction and better health outcomes. These results emphasize the importance of social support as a buffer against stress and a determinant of life satisfaction.

Additionally, some caregiver variables have already been impacted by the caregiving role and can further impact the caregiver and care receiver. For instance, intrapsychic strain due to caregiving may lead to a loss of sense of self and can diminish a sense of competence. These factors can then lead to depression, anxiety, and physical health difficulties. Experiencing

emotional and physical health difficulties can in turn lead the caregiver to renounce their caregiver role. Furthermore, these variables that lead to mental and physical health problems may sometimes be influenced by caregiver personality traits, such as neuroticism, that influence the appraisal of caregiving (Bookwala & Schulz, 1998).

The relationship between the caregiver and care receiver.

Sometimes caregiving can dominate the caregiver's life. Some caregivers see benefits in caregiving, while for others it is extremely stressful (Pearlin et al., 1990). Caregiver stress can result in depression and extreme fatigue that ultimately can lead to dysfunction in the caregiver's personal and professional life. The emotional demands experienced by caregivers can further lead to physical illness which, when coupled with biological vulnerabilities, can place caregivers at significant risk for health problems as well as increased mortality (Schultz & Beach, 1999; Zarit, Stephens, Townsend, & Greene, 1998). In the literature, most of the time, the care receiver is viewed as a stressor to the caregiver, and rarely the relationship between both of them is taken into consideration. When looking at caregiving outcomes, more than just the stress the caregiver experiences must be taken into consideration; for instance, looking at the relationship between care receiver and caregiver may shed light on what makes a good caregiving experience. Understanding how both individuals' perspectives align or clash is pertinent to improving outcomes for both parties.

Lyons, Zarit, Sayer, and Whitlatch (2002) examined the caregiving relationship and the amount of agreement between the caregiver and care receiver: in other words, to what extent they are on "the same page." In contrast to other research suggesting caregiver outcomes are related to care receiver outcomes, Lyons and colleagues found that strain in the relationship is

what leads to negative outcomes in the caregiver. Furthermore, results demonstrated that caregivers have a tendency to appraise the care receiver as more dependent than the care receiver actually is, and as the role of the caregiver becomes more difficult, the discrepancy in appraisal increased. Additionally, results demonstrated caregiving difficulties are predicted by relationship strain. Thus, it appears that we can describe this as a cycle, in which strain in the relationship leads to an increase in discrepancy in appraisal and an increase in caregiving difficulties, thus straining the relationship even more. This cycle can be explained by research, demonstrating that caregiver characteristics, such as the personality trait of neuroticism, can affect caregiver well-being more than care receiver characteristics (Chappell & Kuehne, 1998). At times, having a poor relationship prior to the development of the caregiving relationship can make the caregiving relationship difficult, but this is not always the case. Lyons and colleagues demonstrated that stress affects the caregiver's assessment of the situation and further influences the relationship between the caregiver and care receiver.

Positive and negative outcomes.

While there is a vast amount of information suggesting that caregiving is stressful for caregivers, researchers also suggest that caregiving can lead to positive outcomes. For example, caregiving can provide a sense of mastery, satisfaction, and self-gain. Among European-American caregivers, Chappell (1990) found more than one quarter of family caregivers experienced an increase in life satisfaction as a result of caring for an older family member. An important thing to keep in mind when talking about negative and positive outcomes of caregiving is that family caregivers differ in terms of their relationships to the care receivers, how much they embrace the caregiver role, and the amount, type, and length of care they provide

(Montgomery et al., 2007), thus influencing whether or not caregiving leads to positive or negative outcomes. For instance, Yates, Tennstedt, and Chang (1999) found that hours of care and perception of role overload impacted the relationship between caregiving stressors and depression. Furthermore, they found that the relationship between the caregiver and care receiver mediated the relationship between caregiving stressors, overload, and depression. These results suggest that the relationship between the caregiver and care receiver is mediated by caregiver appraisal and caregiver efficacy and determines the effect of caregiving stressors and overload on the caregiver. An important finding in the Yates et al. (1999) study was that, regardless of stressors, caregivers with high levels of mastery or emotional support had a lower risk of depression. Moreover, it is important to keep in mind that individuals can experience caregiving stress and caregiving satisfaction at the same time. For instance, Montgomery (1992) mentioned that individuals more intensely involved in caregiving and with lower socioeconomic status experience both the satisfaction and the stress of caregiving.

    Social support.

    Social support may be a key determinant of successful caregiving, since social support has been found to be positively correlated to well-being. Thus, social support may protect caregivers from stress and burden by increasing their perception of resources available to handle stress (Cohen, 2004). Caregiving can be very stressful and caregivers need to reach out for help. Caregivers may reach out for formal social support or informal social support. Formal social support includes programs or involving other caregivers that must be paid, while informal social support includes family and friends. Dilworth-Anderson, Williams, and Gibson (2002) reported that ethnic minorities tend to rely more on informal support than formal support. Our personal

network of support may also depend on our culture. For some, it may only include immediate family and friends, whereas for other people, it may extend to include extended family and church members. The social support the individuals in our network provide may include emotional support, instrumental support, and information and advice (Sorking & Rook, 2006). With regard to caregiving, emotional support refers to providing sympathy, affection, understanding, and warmth to the caregiver as a result of their situation. Instrumental support involves the provision of goods and services. In the case of caregiving, this would include helping out the caregiver by providing meals or time for the caregiver to take time off their duties. Information and advice refers to helping out the caregiver find health and financial information.

Sorensen and Pinquart (2005) found that regardless of ethnicity, caregivers who received informal social support had better outcomes for depression and physical health. Unfortunately, social support can at times be negative and create more harm than good on the individual. For instance, Lincoln, Taylor, Bullard, Chatters, Woodward, Himle, and Jackson, (2010) found that negative social support actually exerts damage on our physical and emotional well-being. They examined the relationship between emotional support and negative interaction with family members and found that these two constructs were associated with greater likelihood of having a mood and/or anxiety disorder.

Additionally, there exist gender differences regarding the amount of social support one receives. Because women place more importance on relationships than men, women's networks are usually more extensive than men. Furthermore, because of the importance they place on their relationships versus the superficiality that men place on their relationships, it is easier for them to have more people to meet their needs (Barer, 1994). Usually there would be no problem with this

difference between men and women; however, that is not the case when it comes to caregiving. Ducharme, Levesque, Zarit, Lachance, and Giroux, (2007) found that husband caregivers have the tendency to wait until they are overwhelmed to ask for assistance.

The role of personality.

Some researchers have mentioned personality traits possibly influencing caregiver appraisal and ultimately having an effect on the stress caregivers perceive and the physical and mental health difficulties caregivers develop. Based on previous research showing that personality traits are linked to caregiver's mental and physical health, Lockenhoff, Duberstein, Friedman, and Costa (2011) examined to what extent caregiver burden and self-efficacy mediate the relationship between personality and physical and mental health. Overall, their results replicated previous research, showing a correlation between personality and subjective health.

Furthermore, as hypothesized, Lockenhoff and colleagues found caregiver burden and self-efficacy mediating the correlation between personality and health. Self-efficacy mediated every association between personality and subjective health. In contrast, caregiver burden only mediated the relationship of neuroticism and agreeableness with subjective mental health. Although Lockenhoff and colleagues' results demonstrated partial mediations, their results shed light on the influence of personality and other variables on self-efficacy, burden, and finally outcomes in caregivers. Ultimately, these results demonstrate that personality traits influence caregivers' perceptions of their roles, whether their roles are strenuous or not, and their ability to successfully manage their roles and other aspects of their lives.

Ethnic Group Differences in Caregiving

Overall, caregivers regardless of their ethnicity, race, and cultural differences, report ignoring their own health and well-being as a result of their caregiving responsibilities. Specifically, they report poor eating, sleeping, and exercise habits in conjunction with neglecting themselves when ill and/or visiting the doctor less regularly (Schulz, Newsom, Mittelmark, Burton, Hirsch, Jackson, 1997).

Nevertheless, some research does suggest differences in caregiving incidence, experience, and outcomes, varying by ethnicity, race, and culture. For instance, with regard to the incidence of grandparents caring for grandchildren, the most recent (2010) U.S. Census data demonstrated great variability in grandparents' race/ethnicity, with 51 percent of grandparent caregivers being White, 24 percent Black/African American, and 19 percent Hispanic/Latino (Goyer, 2010). With regard to family members caring for a relative with a mental illness, research by Guarnaccia and Parra (1996) indicates that 75% of Hispanics who suffer from a mental illness live with their family, as opposed to 33% of European-Americans suffering from a mental illness. Moreover, when comparing the amount of time spent between family caregivers and patients, research shows that 73% of Mexican families spend 35 hours or more a week with their relatives with a mental illness, compared to 42% of Anglo-Americans (Lopez, Nelson, Polo, Jenskins, Karno, Vaughn, et al., 2004).

When discussing experience and outcome, Dilworth-Anderson and colleagues' (2002) review of the literature demonstrated that in general, European American caregivers report significantly more depression and burden when compared to their African American counterparts. Furthermore, African Americans experience less role strain than Hispanics and European Americans alike. Factors such as prayer and faith may aid African Americans in their

roles as caregivers when compared to European Americans (Picot, Debanne, Namazi, & Wykle, 1997). Additionally, among Hispanics and African Americans, the concept of familism, which suggests that the well-being of the family takes precedence over that of the individual, influences whether caregiving is seen as an impediment to one's life goals, such as making a career and raising a family, or as an opportunity to better an already positive connection with a parent. However, research findings demonstrate that although familism lowers burden in Hispanics, it does not serve to diminish their depression: in fact, symptoms of depression in Hispanics have been found to be higher than symptoms of depression in African Americans and European Americans (Knight, Robinson, Longmire, Chun, Nakao, and Kim, 2002). A potential explanation for these results is demonstrated by Knight and Sayegh (2010) who found familism related more to obligation rather than solidarity and support.

      Acculturation.

With the recent surge in ethnic minorities in the U.S., the phenomenon of acculturation will continue to play a role in our understanding of ethnic minorities. Numerous definitions have been provided to understand this multifaceted and complex phenomenon. A very early, traditional definition of acculturation states that "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous, first-hand contact with subsequent changes in the original culture patterns of either or both groups (Redfield, Linton, & Herskovits, 1936, p.149)." A more recent, simpler definition by Sam and Berry (2010) indicates that acculturation refers to cultural and psychological changes resulting from different cultures having continuous contact. Adaptation, which refers to psychological well-being or self-esteem and the ability to manage socioculturally - acquiring a new language

for instance - is the result of acculturation. When people from different cultures come into contact, the adaptive process can be multidimensional, such that both cultures can change and adopt different behaviors, attitudes, beliefs, values, languages, social institutions, and technologies (Mena, Padilla, & Maldonado, 1987; Sam & Berry, 2010). Ward (2001) argues that there are three main areas of human life that change during acculturation: affective, behavioral, and cognitive.

Originally, acculturation was conceptualized as a unidimensional construct (Gordon, 1964). Individuals were expected to adapt to the host culture by relinquishing their culture and adopting the host culture's values, behaviors, cognitions, traditions, etc. More recently, researchers have criticized the fact that the unidimensional construct does not allow for biculturalism. Thus, Berry (1997) proposed his acculturation model where he introduces the concepts of assimilation, separation, marginalization, and integration (biculturalism). The problem with Berry's model is that it does not account for the acculturation attitudes adopted by members of the host society towards immigrants and interpersonal and intergroup relational outcomes that are the result of immigrants and the host society's acculturation orientation. Thus, Bourhis, Moise, Perreault, and Senecal (1997) proposed the Interactive Acculturation Model (IAM), which also measures the host society's acculturation attitudes and the relational outcomes of various groups' acculturation orientations. Despite the evolution of the construct, many researchers continue to use unidimensional measurements of acculturation for the purpose of a quick assessment of an individual's acculturation level. An acculturation scale is chosen based on the level of comprehension being sought (Flannery et al., 2001). For the purpose of this study, a bidimensional scale was used to focus on acculturation as the degree of identification with the society of origin as well as with the dominant society.

Familism.

Familism is considered to be a very important cultural value among Hispanic Americans. Originally, familism has referred to the tendency for people of Hispanic and Latino origin to have larger nuclear and extended family networks in which behaviors of loyalty, solidarity, visitation, and exchange are prevalent (Keefe, 1984; Mindel, 1980; Triandis, Marin, Betancourt, Lisansky, & Chang, 1982). Additionally, some researchers have defined it as the tendency to prioritize one's family over oneself. Lugo Steidel and Contreras (2003) suggest that familism is a multidimensional construct composed of three dimensions: structural, attitudinal, and behavioral. "The structural dimension marks the spatial and social boundaries within which behaviors occur and attitudes acquire meaning. These boundaries are delineated by the presence or absence of nuclear and extended family members" (Valenzuela & Dornbusch, 1994). The attitudinal dimension refers to experiencing feelings of loyalty, solidarity, and reciprocity (Keefe, 1984; Mindel, 1980; Triandis et al., 1982). Furthermore, the behavioral dimension refers to acting upon the values of maintaining loyalty, solidarity, and reciprocity through visitation and helping each other out in times of need (Sabogal, Marin & Otero-Sabogal, 1987). The cultural value of familism has been suggested as playing a major role in the day-to-day relationships among nuclear and extended family members of populations of Mexican origin. Experts have reported that African Americans' cultural self may at times also include extended family as well (Dana, 2005).

Broadly speaking, familism is similar to the concept of collectivism (Schwartz, Montgomery, & Briones, 2006). Contrary to what most researchers believe, familism, as measured by the Attitudinal Familism Scale (Lugo Steidel and Contreras, 2003), may take similar forms in Hispanics, Non-Hispanic Whites, and Non-Hispanic Blacks (Schwartz, 2007).

Given the effects of acculturation on familism, Schwartz measured acculturation and found that his sample of Hispanic individuals was in fact highly acculturated, and thus their moderate levels of familism were found to be similar to those of Non-Hispanic Whites and Non-Hispanic Blacks. The authors explain that the high levels of acculturation in the Hispanic group were possibly due to the fact that most Hispanics were U.S. born. Regardless, researchers have found high levels of familism among U.S. born Hispanics who have been raised without much exposure to Hispanic culture (Sabogal et al.,1987). Overall, the fact that Schwartz found similar familism scores among different ethnic groups, one of which is considered individualistic (Non-Hispanic Whites), supports previous findings that indicate that people living in individualistic cultures can have collectivistic values (Coon & Kemmelmeier, 2001; Oyserman, Coon, & Kemmelmeier, 2002).

Acculturation, Familism, and Parental Caregiving

Some factors that influence caregiving patterns are culture, traditions, values, education, and economics, among others. The concept of acculturation has been found to correlate with these factors. For instance, as individuals become more acculturated, their values sometimes shift from their cultural background to those of the mainstream culture. An example of this shows acculturation being inversely associated with the cultural value of familism (Lugo Steidel & Contreras, 2003; Herrera et al., 2008).

With regard to caregiving, the cultural value of familism reminds Hispanic caregivers to accept and fulfill caregiving duties without complaints (Magana, Schwartz, Rupert, & Szapocznik, 2006). However, with the process of acculturation, this cultural value of caring for

an elder at home is strained, with more acculturated individuals seeing caring for an older family member at home as a disturbance (Kao & Travis, 2005).

Similarly, education and socioeconomic status are correlated with acculturation (Berry, 2001). One possible result of the relationship between socioeconomic status and acculturation can be seen in studies demonstrating that Latinos with higher levels of acculturation use health care services (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005) and formal support services (Radina and Baber 2004) more often than less acculturated Latinos. However, other research, contrary to expectation, found that highly acculturated Mexican American caregivers with higher income and more education tended to use less formal long-term care services (Herrera et al., 2008). Furthermore, Herrera and colleagues found that care receivers of high acculturated caregivers tended to not be eligible for Medicaid. This suggests that the relationship between acculturation and caregiving may be due to financial access to long term care. Individuals who are cared for by highly acculturated people with higher incomes and more education are not eligible for Medicaid and thus have to be cared for by their family members, and those who qualify for Medicaid reside in institutions and community-based settings for care. This emphasizes the problem middle-income Americans face in the sense that they do not qualify for Medicaid but they cannot afford services on their own.

Thus, acculturation may be a moderating variable when discussing family caregiving and its related outcomes, such as stress and depression, among minority populations. On one hand, more acculturated individuals follow less traditional values leading them to potentially care-give less; on the other hand, more acculturated individuals may have more income, thus either needing to care-give less or having to care-give more since they may not qualify for government services but be unable to afford services on their own (Herrera et al., 2008).

Jolicoeur and Madden (2002) found that less acculturated Mexican American caregivers experienced greater stress, burden, and significantly lower satisfaction. These caregivers experienced this regardless of the fact that they were fulfilling role obligations and that they had more family members available to assist with caregiving and informal social support. In contrast, Coon (2004) found that Latinas sought less informal social support help than European Americans. A possible explanation was that if they asked for help, it would be assumed that they were feeling burdened and that would be against their cultural tradition of familism. Conflicting results regarding caregivers' following the value of familism and at the same time experiencing more burden and lower satisfaction could be due to several reasons. It may be the case that they are experiencing other sources of stress, low income for instance, or the value of familism in the caregiving context refers more to obligation rather than solidarity (Knight and Sayegh, 2010).

In sum, these findings provide evidence that caring for a disabled family member varies according to ethno-cultural group. Factors like acculturation and familism influence the degree of help provided, the feelings surrounding the task, and the impact the task has on the caregiver. Furthermore, factors like education and income are also related to acculturation and, in turn, potentially influencing caregiving.

Intergenerational Differences Regarding Attitudes about Caregiving

Intergenerational relationships refer to interactions between individuals of different generations (Hayslip, Hicks, & Panek, 2011). These types of relationships occur most often within the context of the family: for instance, the relationship between a grandmother and granddaughter. Intergenerational relationships within the family tend to be better when the individuals in the relationships do not live together and their relationship is fostered based on

wanting to spend time together rather than being forced to have a relationship because they live together. Unfortunately, with the current economic downturn coupled with individuals living longer, intergenerational and even multigenerational households, in which three generations live in the same house, are increasing (U.S. Bureau of the Census, 2000).

When the older adult is disabled, most of the caregiving duties and the burden that comes with them fall on the women of the household. In intergenerational and multigenerational households, these duties are distributed among the women and the burden these women experience can differ between them. Brody, Johnsen, Fulcomer, and Lang (1983) gathered information from three generations of women (older adult women, middle-generation daughters, and young-adult granddaughters) regarding their attitudes towards caring for an older adult. Although the three generations agreed on sharing tasks, their attitudes about sharing child care, parent care, and household tasks differed significantly. Interestingly, even though all three generations agreed that older adults should be able to depend on their adult children for help, older adult women were significantly more receptive than the young and middle-aged adults (granddaughter and daughter) to the idea of obtaining formal services. It may be the case that older adult women responded as mothers who do not want to burden their children. Although the young and middle-aged women demonstrated signs of filial responsibility to the oldest generation, the middle-aged women were more ambivalent about their attitudes regarding formal and informal sources of support. This ambivalence may be the result of being the middle generation and anticipating themselves as care receivers as well as caregivers. The young adult women experienced no ambivalence and were more empathic towards filial responsibility than the other two generations, probably because they cannot yet project themselves psychologically into the role of care receiver or caregiver.

Statement of the Problem

Even though economic hardship and an increase in the population of older adults is a current concern, concerns about caring for a parent have existed across several generations. Dinkel (1944) suggested different reasons why someone would consider giving care to a frail parent: family tradition, community opinion, or legal requirement. Currently, we can assume that people take care of their elder parents for different reasons. For some non-Hispanic White individuals, taking care of a parent may come as a result of monetary difficulties; however, for a Hispanic or non-Hispanic Black individual, taking care of a parent may also be the result of the cultural value of familism. Attitudes about caregiving for a parent may reflect the reason why someone would or would not take on such a responsibility.

The research regarding the impact of familism and acculturation on caregiving and burden is mixed. Thus, the goal of this project is to understand ethnic differences in attitudes towards caregiving and expected burden while taking into consideration factors such as gender, generation, familism, and acculturation. This study has implications for education about when informal and formal sources of support should be provided with the hope of preventing or diminishing burden and/or depression as a result of caregiving.

The following hypotheses were investigated:

Hypothesis 1.

Ethnicity relates to attitudes towards caregiving, moderated by gender, generation, familism, and acculturation. Interest is on how each moderator independently moderates the relationship between ethnicity and attitudes towards caregiving and thus this relationship will be investigated for each moderator separately.

Hypothesis 1A. Ethnicity relates to a monitoring attitude towards caregiving, moderated by gender, generation, familism, and acculturation (ethnic society immersion and dominant society immersion) separately.

Hypothesis 1B. Ethnicity relates to a nurturing attitude towards caregiving, moderated by gender, generation, familism, and acculturation (ethnic society immersion and dominant society immersion) separately.

Hypothesis 2.

Ethnicity and expected burden relate, moderated by gender, generation, familism, and acculturation (ethnic society immersion and dominant society immersion). Interest is on how each moderator independently moderates the relationship between ethnicity and expected burden and thus this relationship will be investigated for each moderator separately.

All of the above will first control for level of social desirability, personality (neuroticism and openness), social support, and how much one behaves according to one's values regarding their relationship with their parent.

These hypotheses are based on different research suggesting that providing care for a family member at home varies per ethnicity/race (Goyer, 2010; Guarnaccia and Parra, 1996; Lopez, et al., 2004). Possible factors responsible for some groups being more or less likely to provide care at home may be those of acculturation and familism (Knight and Sayegh, 2010). Of equal importance are factors such as gender, age, and personality. Researchers have demonstrated gender differences in caregiving (Montgomery et al., 2007), generational differences in attitudes towards caregiving (Brody et al., 1983), and some personality factors making someone more vulnerable to caregiver stress (Chappell & Kuehne, 1998).

CHAPTER 2

Method

Participants

Of 209 participants, 139 were female (66.5% of the sample) and 70 were male (33.5% of the sample). One hundred and sixteen participants were young adults (ages 18-25; 55.5% of the sample) and 93 were middle-age adults (ages 38-62; 44.5% of the sample). Regarding ethnicity, 80 individuals reported being European American (38.3% of the sample), 64 African American 30.6% of the sample), and 65 Hispanic 31.1% of the sample). Seventy-three individuals were married (34.9% of the sample), 12 divorced (5.7% of the sample), 2 separated (1.0% of the sample), 112 single (never married; 53.6% of the sample), 9 living with a committed partner (4.3% of the sample), and 1 widowed (.5% of the sample). Regarding socioeconomic status (income and education), 56 participants (26.8%) reported having an annual income of more than $100,000 dollars. Sixty one participants (29.2%) reported an annual income between $50,000 and $100,000, 25 participants (12.0%) reported an annual income between $40,000 and $50,000, 19 participants (9.1%) an annual income between $30,000 and $40,000, 13 participants (6.2%) an annual income between $20,000 and $30,000, 14 participants (6.7%) an annual income between $10,000 and $20,000 and 17 participants (8.1%) an annual income of less than $10,000. Seventy-five participants (35.9%) reported having completed 16 years or more of education. Thirty-three participants (15.8%) reported 15 years of education, Twenty-nine participants (13.9%) reported 14 years of education, eighteen participants (8.6%) reported 13 years of education, twenty-two participants (10.5%) reported 12 years of education and 26 participants (12.6%) completed less than 12 years of education.

Procedure

Participants were undergraduate students or friends/relatives of students from psychology courses taught at the University of North Texas in 2013. Middle age adults recruited into the study were not related to the young adult participants as middle age adults were recruited through college students that did not participate as research participants in the study. Students turned in surveys in sealed envelopes with the participant's contact information on the outer envelope. Surveys without this contact information were not accepted. Random surveys from each student were chosen for verification; those participants not enrolled in the class were contacted via phone to ensure the participants had received and answered the survey themselves. College students received credit for their participation or the participation of the middle-age adult they recruited. Individuals who provided full time care for an individual 5 years prior to answering the questionnaire were not enrolled in the study.

Materials

Demographic information questionnaire.

This questionnaire was designed for the purpose of this study, and consisted of questions designed to characterize our sample. This questionnaire was designed to obtain information regarding gender, age, ethnicity/race, marital status, number of children, income, and education.

Attitudes about caregiving.

The Beliefs about Caregiving Scale (BACS; Phillips, Rempusheski, & Morrison, 1989) was designed with the purpose of identifying family caregivers at risk for abusing the care receiver. The BACS was used in this study to measure caregivers' beliefs about what they think

their approach to caregiving would look like. This is a 28-item Likert-type scale composed of two subscales: monitoring and nurturing. Sixteen items measure monitoring, which involves the caregivers' beliefs that he or she must control the care receiver's behaviors. An example of an item is: "Laying down the law to my elder is something I must do." Twelve items measure nurturing, which involves the caregivers' beliefs about subordinating the caregiver's needs to those of the care receiver. An example of an item is this: "I have the responsibility of arranging my daily activities to accommodate my elder's social needs."

Caregiver expected burden.

The Zarit Burden Interview (Zarit, Reever & Bach-Peterson, 1980) originated as a 29-item questionnaire and was later revised to a 22-item questionnaire (Zarit & Zarit, 1983). Each item is endorsed on a 5-point Likert scale, which ranges from 0 (never) to 4 (nearly always). An example of an item is: "Do you feel you have lost control of your life since your relative's illness?" Herbert, Bravo, and Preville (2000) provide information on the Zarit Burden Interview reliability and validity and demonstrate that the measure has good internal consistency reliability (Cronbach's alpha = .92). Furthermore, Herbert et al., (2000) demonstrated the measure is appropriate for use with a variety of populations, since scores were not related to age, gender, marital status, and employment status.

Acculturation.

To measure acculturation, the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) was used in the study. This scale assesses orientation toward heritage (17 items, Cronbach's alpha of .89) and American cultural practices (15 items, Cronbach's alpha of

.84). In the creation of the SMAS, Stephenson defined acculturation as the degree of immersion in dominant and ethnic societies; thus two subscales originate from this instrument, dominant society immersion and ethnic society immersion. Through the SMAS, immersion is measured through behaviors such as language, interaction, food, and media. Such a conceptualization of acculturation allows for its application across different ethnic groups. This scale does not measure adoption of new beliefs and values, but what group the individual identifies most with (dominant group versus country of origin group). Sample items include, "I like to eat American foods" and "I like to listen to music of my ethnic group."

Familism.

The cultural value of familism was measured with the Attitudinal Familism Scale (Lugo Steidel & Contreras, 2003). This is an 18-item, self-report measure regarding the extent to which one values family and the role family plays in one's life. This scale reflects four main components of attitudinal familism as proposed by Lugo Steidel and Contreras (2003). The first component of attitudinal familism is the belief that the family comes before the individual; this means that due to the importance of the family, its members are expected to give up their own needs and desires for those of the family. The second component is familial interconnectedness, which means that adults, even though they become independent, are expected to maintain strong emotional and physical ties with the family. The third component of attitudinal familism is the idea of familial reciprocity in times of need. Finally, the fourth component of attitudinal familism is the idea of familial honor. Familial honor means that family members are expected to upkeep, protect, and defend the family name (Lugo Steidel & Contreras, 2003). Lugo Steidel and Contreras (2003) reported a Cronbach's alpha for the overall scale of .83.

The Attitudinal Familism Scale was created with a sample of Spanish-dominant residents living in an adult community. However, Schwartz (2007) found that the applicability of familism across Hispanic groups did not differ based on acculturation or age. Furthermore, he found familism to take similar forms in Hispanic and non-Hispanic groups. Thus, this scale of attitudinal familism will be used for Hispanics, Non-Hispanic Whites and Non-Hispanic Blacks. An example of an item is: "A person should live near his or her parents and spend time with them on a regular basis."

Personality.

Neuroticism and openness were measured with the NEO Five-Factor Inventory (NEO-FFI; Costa & McCrae, 1992). Neuroticism and openness were measured in this study as control variables. The 60-item NEO-FFI was developed to provide a succinct measure of the five basic personality factors: neuroticism, extroversion, openness, agreeableness, and conscientiousness (Costa & McCrae, 1989). For each factor, 12 items were selected from 180 NEO Personality Inventory (NEO-PI) items. The 60-item version uses a five-point Likert-type scale. Robin, Fraley, Roberts & Trzesniewski (2001) demonstrated high two-week retest reliability for the five scales (0.86 to 0.90). Similarly, Costa and McCrae (1992) demonstrated good internal consistency (0.68 to 0.86). Although the NEO-FFI has shown itself to be reliable, valid, and useful in research settings, it has been revised two times. McCrae and Costa (2004) suggested changes to 14 items of the 60 NEO-FFI items and found modest improvements. They suggested that for most purposes, the original NEO-FFI continues to be adequate.

Social support.

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was designed with university undergraduate students for the purpose of measuring familial, friendships, and significant other support. The MSPSS was used in this study as a control variable. This is a 12-item Likert-type scale ranging from (1) very strongly disagree to (7) very strongly agree. Items in the MSPSS address social support divided amongst factor groups relating to the source of support (family, friends, significant other). Each factor consisted of four items. An example of an item is: "There is a special person who is around when I am in need." Cronbach's alpha for the total scale was .88 (Zimet, Dahlem, Zimet, & Farley, 1988).

Social desirability.

The Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne and Marlowe, 1960) is a 33-item measure commonly used to assess social desirability and the manner in which one portrays themselves. The measure consists of self-report true-false items related to everyday common behaviors. Several shorter versions of the MCSDS have been created. For the purpose of this study eight items (6, 13, 15, 16, 19, 21, 34, and 35) from the original scale were selected based on the Cronbach's alphas of .77 and .74 when these items have been administered together (Greenwald & Satow, 1970; Strahan & Gerbasi, 1972).

Values.

The Personal Values Questionnaire II (Blackledge, Ciarocchi, & Bailey, 2007) is a self-report measure used to assess value domains and rule-governed behavior. This questionnaire asks participants to identify values across nine domains: family relationships, friendships/social

relationships, couples/romantic relationship, work/career, education-schooling/personal growth

and development, recreation/leisure/sport, spirituality/religion, community/citizenship, and

health/physical well-being. Respondents then are asked to respond to five statements about the

rule-governed behavior associated with the values on a five point likert scale ranging from 1 "not

at all important" or "Strongly disagree" to 5 "extremely important" or "strongly agree." Rule-

governed behavior questions are designed to assess the motivation behind the values, to rate the

importance of each value, and to assess commitment to the value. For the purpose of this study

this questionnaire was used only to assess rule-governed behavior in relation to the value of

parent-child relationships. There is currently no psychometric data on this instrument (Blacklege

& Ciarocchi, 2005). Example of items are: "How committed are you to living this value?" and "I

would feel guilty or ashamed if these values were not important to me."

CHAPTER 3

Results

Initial Data Analysis

The current study was proposed in order to examine the moderating effect of gender, generation, familism, and acculturation (level of immersion in both ethnic and dominant societal cultures) in the relationship between ethnicity, and attitudes towards caregiving and individuals' expectations of burden in the future. A total of 400 participants completed the survey. Following data collection, all completed surveys were entered into SPSS and examined for data entry errors and missing data. SPSS computer randomization selected the European American sample since there was over recruitment of European Americans. Ten participants had less than 30% of data missing for some scales, and thus means for those variables were entered in place of missing data. Eleven participants' data was also omitted because they had provided care to an individual within the past five years. Four participants had to be excluded due to missing data regarding their age and/or date of birth. This left a final sample of 209 individuals for data analysis. Acculturation subscales of ethnic society immersion and dominant society immersion were moderately negatively skewed, thus they were restored to normality via square root transformation (Tabachnick & Fidel, 2006). Means and standard deviations for these two variables are reported on the nontransformed data.

Attitudes Towards Caregiving: Monitoring and Nurturing

Means and standard deviations are reported for both attitudes (monitoring and nurturing) towards caregiving subscales (see Table 1). Analysis of variance (ANOVA) and independent samples t-tests were conducted to examine ethnicity, generation, and gender differences in

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subscales of monitoring and nurturing. Results of the ANOVA did not indicate ethnic differences in individuals' attitudes towards caregiving: (monitoring) $F (2, 206) = 2.146, p > .05$; (nurturing) $F (2,206) = 1.646, p > .05$. Independent sample t-tests demonstrated generational differences in the subscale of nurturing, $t (207) = 2.511, p < .01$, with young adults reporting higher nurturance when compared to their middle-aged adult counterparts. A second independent sample t-test also demonstrated gender differences in the subscale of nurturing, $t (207) = -2.659, p < .01$, with females reporting higher nurturance when compared to males.

Table 1
Means and Standard Deviations for Attitudes Towards Caregiving

	Monitoring *(SD)*	Nurturing *(SD)*
Ethnicity		
European American	34.85 (6.13)	38.49 (4.86)
African American	37.14 (7.97)	40.23 (6.12)
Hispanic	36.86 (8.01)	39.34 (6.35)
Generation		
Young Adult	36.35 (7.10)	40.17 (5.24)
Middle Age Adult	35.97 (7.73)	38.18 (6.22)
Gender		
Male	36.79 (7.62)	37.81 (6.85)
Female	35.87 (7.26)	40.03 (5.00)

Expected Burden

Means and standard deviations are reported for individuals' expected burden when having to provide care for an older adult parent in the future (Table 2). Analysis of variance comparing ethnicity in expected burden did not show significant differences $F (2, 206) = 1.575$, $p > .05$. Independent samples t-tests also did not find significant differences due to generation $t (207) = .649, p > .05$ or gender $t (207) = .609, p > .05$.

Table 2

Means and Standard Deviations for Expected Burden

Ethnicity	
European American	35.45 (14.18)
African American	31.09 (19.66)
Hispanic	31.39 (16.37)
Generation	
Young Adult	33.53 (16.73)
Middle Age Adult	32.01 (16.80)
Gender	
Male	31.86 (15.48)
Female	33.35 (17.37)

Familism

Means and standard deviations are reported for the different familism subscales and the

overall familism scale (Table 3). ANOVAs and independent samples t-tests were conducted to

examine differences between ethnicity, generation, and gender on subscales of familism.

ANOVA demonstrated ethnic differences in all subscales of familism. Familial Support, F

$(2,206) = 3.32$, $p < .05$, was significantly different for European Americans and African

Americans. Based on Scheffe's post hoc test ($p < .05$), African Americans reported significantly

more familial support than European Americans. Familial Interconnectedness, $F (2, 206) = 4.84$,

$p < .01$, was significantly different for European Americans and African Americans. Based on

Scheffe's post hoc test ($p < .05$) African Americans reported significantly more familial

interconnectedness than European Americans. Familial Honor, $F (2, 206) = 3.79$, $p < .05$, was

significantly different for European Americans and Hispanics. Hispanics reported significantly

more familial honor than European Americans ($p<0.05$). Subjugation of Self for Family, F

$(2,206) = 6.56$, $p < .01$, was significantly different for European Americans when compared to

African Americans and Hispanics. Both minority groups reported significantly more

subjugations of self for family than European Americans (African Americans $p < .01$; Hispanics

p < .05). The overall Familism scale, $F(2, 206) = 6.87$, *p* < .01, was significantly different for European Americans when compared to African Americans and Hispanics, with both minority groups reporting higher familism than European Americans (African Americans, *p* < .01; Hispanics *p* < .05). Generational and gender differences were not observed in any of the familism subscales.

Table 3
Mean and Standard Deviations for Familism

	Familial Support	Familial Interconnectedness	Familial Honor	Subjugation of Self for Family	Overall Familism
Ethnicity					
European American	3.65 (.59)	4.17 (.48)	2.59 (.53)	3.34 (.75)	3.51 (.42)
African American	3.91 (.65)	4.42 (.54)	2.81 (.74)	3.75 (.80)	3.78 (.55)
Hispanic	3.82 (.62)	4.35 (.47)	2.88 (.73)	3.72 (.78)	3.74 (.48)
Generation					
Young Adult	3.85 (.62)	4.33 (.48)	2.76 (.72)	3.64 (.81)	3.71 (.51)
Middle Age Adult	3.70 (.63)	4.26 (.53)	2.72 (.61)	3.52 (.78)	3.61 (.47)
Gender					
Male	3.81 (.53)	4.21 (.51)	2.77 (.63)	3.52 (.73)	3.64 (.45)
Female	3.77 (.67)	4.35 (.50)	2.73 (.69)	3.62 (.83)	3.68 (.52)

Acculturation

Means and standard deviations are reported for individuals' degree of immersion in both ethnic and dominant societies (Table 4). Analysis of variance and independent samples t-tests were conducted to examine differences due to ethnicity, generation, and gender on subscales of ethnic society immersion and dominant society immersion. The ANOVA indicated significant ethnic differences for the ethnic society immersion subscale, $F(2, 206) = 3.154$, *p* < .05. Scheffe's post hoc test indicated significant differences between European Americans and Hispanics in their immersion to ethnic society (*p* < .05), with European Americans reporting significantly higher ethnic society immersion than Hispanics. An additional investigation looking

at ethnic differences in dominant society immersion was also significant, F (2, 206) = 13.401, p < .01, with European Americans reporting significantly greater dominant society immersion than African Americans (p < .01) and Hispanics (p < .01). An independent sample t-test demonstrated generational differences in the subscale of ethnic society immersion, t (206.505) = -3.028, p < .01, with middle-aged adults reporting higher ethnic society immersion than their young adult counterparts. A second independent sample t-test did not find generational differences in dominant society immersion, t (207) = -1.574, p > .05. Regarding gender differences, independent sample t-tests did not indicate gender differences on either of the acculturation subscales (ethnic society immersion, t (207) = -1.230, p > .05; dominant society immersion t (207) = -1.516, p > .05).

Table 4
Means and Standard Deviations for Acculturation

	Ethnic society immersion *(SD)*	Dominant society immersion *(SD)*
Ethnicity		
European American	3.41 (.08)	3.66 (.02)
African American	3.33 (.08)	3.48 (.05)
Hispanic	3.08 (.08)	3.36 (.05)
Generation		
Young Adult	3.15 (.76)	3.47 (.35)
Middle Age Adult	3.45 (.60)	3.57 (.40)
Gender		
Male	3.18 (.68)	3.44 (.36)
Female	3.34 (.72)	3.54 (.38)

Hypothesis Testing

Assumptions of regression, including normality, linearity, homoscedasticity, and multicollinearity, were tested. For moderation analyses, the predictor variable (ethnicity) was dummy coded, moderator variables (gender, generation, familism, and acculturation) were centered to prevent multicollinearity, and interaction terms were created (Frazier, Barron, & Tix, 2004). A correlation matrix for the variables of interest is presented in Appendix A.

Hypothesis 1.

To test the first hypothesis, which suggests that gender, generation, familism, and acculturation moderate the relationship between ethnicity and attitudes towards caregiving, various hierarchical multiple regression analyses were conducted. This hypothesis was divided in two hypotheses - hypothesis 1A and hypothesis 1B - due to the variable of attitudes towards caregiving having two subscales, monitoring and nurturing.

Hypothesis 1A. Hypothesis 1A investigated whether gender, generation, familism, and acculturation moderate the relationship between ethnicity and having a monitoring attitude towards caregiving. Having a monitoring attitude towards caregiving suggests a belief that one should control the older adult's behavior using any means necessary. Each moderator was investigated in a separate regression analysis.

Monitoring attitude and gender as a moderator. The first regression analysis looked at gender as a moderator in the relationship between ethnicity and a monitoring attitude towards caregiving (Table 5). In the first step of the regression analysis, five control variables were entered: social desirability, neuroticism, openness, social support, and values purity. These variables together accounted for a significant amount of variance in having a monitoring attitude towards caregiving, $R^2 = .055$, $F(5, 203) = 2.385$, $p < .05$. Although social desirability, openness, social support, and values purity were not significant predictors independently, neuroticism, $b = .215$, $t(203) = 2.904$, $p < .01$, was a significant independent predictor of a monitoring attitude towards caregiving.

Ethnicity scores were entered in the second step of the regression analysis. Although entering the dummy coded variables of ethnicity together did not add predictive power, $\Delta R^2 =$.

026, $F (2, 201) = 2.851$, $p > .05$, being African American relative to European American predicted having a monitoring attitude towards caregiving, $b = .18$, $t (201) = 2.344$, $p < .05$. Next, the moderator variable of gender was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in monitoring attitudes towards caregiving, $\Delta R^2 = .008$, $F (1, 200) = 1.821$, $p > .05$. The fourth step of the regression analysis included the interaction term between ethnicity (African American compared to European American) and gender. This interaction did not account for any variance in monitoring attitudes towards caregiving, $\Delta R^2 = .000$, $F (1, 199) = .022$, $p > .05$. In the final step of the regression, the interaction between ethnicity (Hispanic compared to European American) and gender was entered. This interaction also did not account for any variance in monitoring attitudes towards caregiving $\Delta R^2 = .004$, $F (1, 198) = .942$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 5

Summary of hierarchical regression analysis for having a monitoring attitude towards caregiving with gender as a moderator.

Variable	Step 1 B	SE B	β	Step 2 B	SE B	β	Step 3 B	SE B	β	Step 4 B	SE B	β	Step 5 B	SE B	β
Control Variables															
Social Desirability	.20	.13	.11	.18	.13	.10	.21	.13	.12	.21	.13	.12	.21	.13	.12
Neuroticism	.20	.07	.22**	.22	.07	.23**	.24	.07	.26**	.23	.07	.26**	.23	.07	.25**
Openness	-.06	.08	-.05	-.07	.08	-.06	-.08	.08	-.07	-.07	.08	-.07	-.07	.08	-.06
Social Support	.05	.04	.09	.06	.04	.11	.07	.04	.12	.06	.04	.12	.06	.04	.11
Values Purity	-.27	.20	-.09	-.26	.20	-.09	-.23	.20	-.08	-.23	.20	-.08	-.25	.20	-.09
Predictor															
African American				2.88	1.23	.18*	2.87	1.23	.18*	2.62	2.05	.16	1.69	2.26	.11
Hispanic				1.74	1.21	.11	1.48	1.22	.09	1.46	1.23	.09	-.16	2.07	-.01
Moderator															
Gender							-1.49	1.10	-.10	-1.59	1.31	-.10	-2.81	1.82	-.18
Interactions															
African American* Gender										.35	2.34	.02	1.59	2.67	.09
Hispanic* Gender													2.50	2.58	.13
R	.236			.286			.300			.300			307		
R2	.055			.082			.090			.090			.094		
R2 Change	.055			.026			.008			.000			.004		
F for change in R2	2.385*			2.851			1.821			.022			.942		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Monitoring attitude and generation as a moderator. The second regression analysis looked at generation (young adult versus middle age adult) as a moderator in the relationship between ethnicity and a monitoring attitude towards caregiving (Table 6). After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of generation was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in monitoring attitudes towards caregiving, $\Delta R^2 = .000$, $F(1, 200) = .036$, $p > .05$. The fourth step of the regression analysis included the interaction term between ethnicity (African American) and generation. This step did not account for any variance in monitoring attitudes towards caregiving, $\Delta R^2 = .001$, $F(1, 199) = .279$, $p > .05$. The last step of the regression included the interaction term between ethnicity (Hispanic) and generation. Similarly, this step also did not account for any additional variance $\Delta R^2 = .001$, $F(1, 198) = .287$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 6

Summary of hierarchical regression analysis for having a monitoring attitude towards caregiving with generation as a moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.20	.13	.11	.18	.13	.10	.18	.13	.10	.19	.13	.11	.19	.13	.11
Neuroticism	.20	.07	.22**	.22	.07	.23**	.22	.07	.23**	.22	.07	.23**	.22	.07	.23**
Openness	-.06	.08	-.05	-.07	.08	-.06	-.07	.08	-.07	-.07	.08	-.06	-.07	.08	-.06
Social Support	.05	.04	.09	.06	.04	.11	.06	.04	.11	.06	.04	.11	.06	.04	.11
Values Purity	-.27	.20	-.09	-.26	.20	-.09	-.26	.20	-.09	-.28	.21	-.10	-.28	.21	-.10
Predictor															
African American				2.88	1.23	.18*	2.86	1.24	.18*	3.38	1.58	.21*	3.07	1.68	.19
Hispanic				1.74	1.21	.11	1.73	1.21	.11	1.74	1.22	.11	1.13	1.66	.07
Moderator															
Generation							-.20	1.08	-.01	.15	1.28	.01	-.42	1.67	-.03
Interaction															
African American* Generation										-1.19	2.26	-.05	-.60	2.52	-.03
Hispanic* Generation													1.32	2.46	.06
R		.236			.286			.286			.288			290	
R2		.055			.082			.082			.083			.084	
R2 Change		.055			.026			.000			.001			.001	
F for change in R2		2.385*			2.851			0.36			.279			.287	

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Monitoring attitude and familism as a moderator. The third regression analysis looked at familism as a moderator in the relationship between ethnicity and a monitoring attitude towards caregiving (Table 7). After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of familism was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in monitoring attitudes towards caregiving, $\Delta R^2 = .002$, $F(1, 200) = .438$, $p > .05$. In the fourth step of the regression analysis, the interaction term between ethnicity (African American) and familism was entered. This step did not account for any variance in monitoring attitudes towards caregiving, $\Delta R^2 = .007$, $F(1, 199) = 1.446$, $p > .05$. The final step included the interaction between ethnicity (Hispanic) and familism. This step also did not account for any variance in monitoring attitudes towards caregiving, $\Delta R^2 = .008$, $F(1, 198) = 1.760$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 7

Summary of hierarchical regression analysis for having a monitoring attitude towards caregiving with familism as a moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
***Co*ntrol Variables**															
Social Desirability	.20	.13	.11	.18	.13	.10	.16	.13	.09	.15	.13	.09	.15	.13	.08
Neuroticism	.20	.07	.22**	.22	.07	.23**	.21	.07	.23**	.22	.07	.24**	.22	.07	.24**
Openness	-.06	.08	-.05	-.07	.08	-.06	-.06	.08	-.06	-.07	.08	-.06	-.06	.08	-.06
Social Support	.05	.04	.09	.06	.04	.11	.05	.04	.10	.06	.04	.10	.06	.04	.09
Values Purity	-.27	.20	-.09	-.26	.20	-.09	-.25	.20	-.09	-.23	.20	-.08	-.23	.20	-.08
Predictor															
African American				2.88	1.23	.18*	2.66	1.27	.17*	2.71	1.27	.17*	2.99	1.29	.19*
Hispanic				1.74	1.21	.11	1.57	1.24	.10	1.32	1.25	.08	1.47	1.26	.09
Moderator															
Familism							.72	1.09	.05	1.77	1.40	.12	-.02	1.94	-.02
Interaction															
African American* Familism										-2.58	2.14	-.11	-.77	2.53	-.03
Hispanic* Familism													3.56	2.68	.13
R		.236			.286			.289			.300			.313	
R2		.055			.082			.084			.090			.098	
R2 Change		.055			.026			.002			.007			.008	
F for change in R2		2.385*			2.851			0.438			1.446			1.760	

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Monitoring attitude and ethnic society immersion as a moderator. The fourth regression analysis looked at ethnic society immersion as a moderator in the relationship between ethnicity and a monitoring attitude towards caregiving (Table 8). The ethnic society immersion subscale measures the degree of immersion in the domains of language, interaction, food, and media in one's ethnic group. After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of "ethnic society immersion" was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in monitoring attitudes towards caregiving, $\Delta R^2 = .002$, $F(1, 200) = .367$, $p > .05$. The fourth step included the interaction between ethnicity (African American) and ethnic society immersion. This step did not account for any variance in monitoring attitudes towards caregiving $\Delta R^2 = .001$, $F(1, 199) = .263$, $p > .05$. In the final step the interaction between ethnicity (Hispanic) and ethnic society immersion was entered into the regression model. Similarly, this step was not significant, $\Delta R^2 = .005$, $F(1, 198) = 1.026$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 8

Summary of hierarchical regression analysis for having a monitoring attitude towards caregiving with following an ethnic society as moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.20	.13	.11	.18	.13	.10	.17	.13	.09	.17	.13	.09	.15	.13	.09
Neuroticism	.20	.07	.22**	.22	.07	.23**	.22	.07	.24**	.22	.07	.24**	.22	.07	.24**
Openness	-.06	.08	-.05	-.07	.08	-.06	-.07	.08	-.06	-.07	.08	-.06	-.07	.08	-.06
Social Support	.05	.04	.09	.06	.04	.11	.06	.04	.11	.06	.04	.11	.05	.04	.10
Values Purity	-.27	.20	-.09	-.26	.20	-.09	-.26	.20	-.09	-.26	.20	-.08	-.25	.20	-.08
Predictor															
African American				2.88	1.23	.18*	2.92	1.23	.18*	2.87	1.24	.18*	2.80	1.24	.18*
Hispanic				1.74	1.21	.11	1.86	1.23	.12	1.80	1.25	.11	1.93	1.25	.12
Moderator															
Ethnic Society							.34	.57	.04	.16	.67	.02	-.35	.83	-.04
Interaction															
African American* Ethnic										.63	1.24	.04	1.16	1.34	.08
Hispanic* Ethnic	.												1.43	1.41	.09
R		.236			.286			.288			.291			.299	
R2		.055			.082			.083			.084			.089	
R2 Change		.055			.026			.002			.001			.005	
F for change in R2		2.385*			2.851			0.367			.263			1.026	

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Monitoring attitude and dominant society immersion as a moderator. The fifth

regression analysis looked at dominant society immersion as a moderator in the relationship

between ethnicity and a monitoring attitude towards caregiving (Table 9). The dominant society

immersion subscale measured the degree of immersion in the domains of language, interaction,

food, and media within the dominant society. After entering the five control variables in the first

step and the dummy coded ethnicity variables in the second step, the moderator variable of

dominant society immersion was entered into the third step of the regression. The moderator

variable did not account for a significant amount of additional variance in monitoring attitudes

towards caregiving, $\Delta R^2 = .001$, $F(1, 200) = .220$, $p > .05$. The fourth step of the regression

included the interaction between ethnicity (African American) and dominant society immersion.

Results of this step were not significant, $\Delta R^2 = .005$, $F(1, 199) = 1.181$, $p > .05$. In the final step

of the regression analysis, the interaction term between ethnicity (Hispanic) and dominant

society immersion was entered and also did not account for any variance in monitoring attitudes

towards caregiving, $\Delta R^2 = .011$, $F(1, 198) = 2.315$, $p > .05$. At each step of this regression

analysis, predictors did not explain additional unique variance in the dependent variable.

Table 9

Summary of hierarchical regression analysis for having a monitoring attitude towards caregiving with following a dominant society as moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β
Control Variables															
Social Desirability	.20	.13	.11	.18	.13	.10	.18	.13	.10	.17	.13	.09	.17	.13	.10
Neuroticism	.20	.07	.22**	.22	.07	.23**	.21	.07	.23**	.22	.07	.23**	.21	.07	.23**
Openness	-.06	.08	-.05	-.07	.08	-.06	-.06	.08	-.05	-.06	.08	-.05	-.07	.08	-.06
Social Support	.05	.04	.09	.06	.04	.11	.06	.04	.11	.07	.04	.12	.06	.04	.11
Values Purity	-.27	.20	-.09	-.26	.20	-.09	-.27	.20	-.09	-.28	.20	-.09	-.23	.20	-.08
Predictor															
African American				2.88	1.23	.18*	2.74	1.27	.17*	2.63	1.27	.17*	1.79	1.38	.11
Hispanic				1.74	1.21	.11	1.53	1.29	.10	1.16	1.34	.07	.60	1.38	.04
Moderator															
Dominant Society							-.63	1.35	-.04	-1.81	1.73	-.10	-6.50	3.53	-.36
Interaction															
African American* Dominant										2.92	2.69	.10	7.60	4.08	.25
Hispanic* Dominant													6.19	4.07	.23
R	.236			.286			.287			.297			.314		
R2	.055			.082			.083			.088			.099		
R2 Change	.055			.026			.001			.005			.011		
F for change in R2	2.385*			2.851			0.220			1.181			2.315		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Hypothesis 1B. Hypothesis 1B investigated whether gender, generation, acculturation, and familism moderate the relationship between ethnicity and having a nurturing attitude towards caregiving. Having a nurturing attitude towards caregiving suggests one believes that one should provide care to an older adult using comfortable and effective strategies. Each moderator was investigated in a separate regression analysis.

Nurturing attitude and gender as a moderator. The first regression analysis looked at gender as a moderator in the relationship between ethnicity and a nurturing attitude towards caregiving (Table 10). In the first step, five control variables were entered: social desirability, neuroticism, openness, social support, and values purity. These variables accounted for a significant amount of variance in having a nurturing attitude towards caregiving, $R^2 = .148$, $F (5, 203) = 7.039$, $p < .01$. Specifically, the variables of social desirability, $b = .23$, $t (203) = 3.284$, $p < .01$, openness, $b = .16$, $t (203) = 2.363$, $p < .05$, and social support, $b = .29$, $t (203) = 4.317$, $p < .01$, significantly predicted having a nurturing attitude towards caregiving for an older adult. Ethnicity scores were entered in the second step. Although entering the dummy coded variables of ethnicity together did not add predictive power, $\Delta R^2 = .018$, $F (2, 201) = 2.170$, $p > .05$, being African American relative to European American predicted unique variance in having a nurturing attitude towards caregiving, $b = .15$, $t (201) = 2.082$, $p < .05$. Next, the moderator variable of gender was entered into the third step of the regression and accounted for a significant amount of variance, $\Delta R^2 = .024$, $F (1, 200) = 6.044$, $p < .01$, with females having a higher nurturing attitude towards caregiving than males. The fourth step of the regression analysis included the interaction between ethnicity (African American) and gender. This interaction term was not significant, $\Delta R^2 = .006$, $F (1, 199) = 1.420$, $p > .05$. In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and gender was

entered. This also did not account for any unique variance in nurturing attitudes towards caregiving, $\Delta R^2 = .010$, $F(1, 198) = 2.408$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 10

Summary of hierarchical regression analysis for having a nurturing attitude towards caregiving with gender as a moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.32	.10	.23**	.31	.10	.22**	.27	.10	.20**	.28	.10	.20**	.28	.10	.20**
Neuroticism	.05	.05	.07	.07	.05	.09	.04	.05	.05	.03	.05	.05	.03	.05	.04
Openness	.14	.06	.16*	.13	.06	.15*	.14	.06	.16*	.14	.06	.16*	.14	.06	.16*
Social Support	.13	.03	.29**	.13	.03	.30**	.13	.03	.29**	.13	.03	.29**	.13	.03	.29**
Values Purity	.12	.15	.05	.12	.15	.05	.08	.15	.03	.08	.15	.03	.05	.15	.02
Predictor															
African American				1.91	.92	.15*	1.93	.90	.16*	.49	1.51	.04	-.60	1.66	-.05
Hispanic				.89	.90	.07	1.24	.90	.10	1.14	.91	.09	-.76	1.52	-.06
Moderator															
Gender							2.00	.81	.16*	1.37	.96	.11	-.05	1.33	-.00
Interaction															
African American* Gender										2.05	1.72	.15	3.50	1.95	.25
Hispanic* Gender													2.93	1.89	.20
R	.384			.407			.436			.443			.453		
R2	.148			.166			.190			.196			.206		
R2 Change	.148			.018			.024			.006			.010		
F for change in R2	7.039**			2.170			6.044*			1.420			2.408		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Nurturing attitude and generation as a moderator. We looked at generation as a

moderator in the relationship between ethnicity and a nurturing attitude towards caregiving

(Table 11). After entering the five control variables in the first step and the dummy coded

ethnicity variables in the second step, the moderator variable of generation was entered into the

third step of the regression. The moderator variable accounted for a significant amount of

additional variance in nurturing attitudes towards caregiving, $\Delta R^2 = .019$, $F(1, 200) = 4.635$, $p <$

.05, with younger adults having a higher reported nurturing attitude towards caregiving than

middle-aged adults. The fourth step of the regression included the interaction term between

ethnicity (African American) and generation. This step did not account for any variance in

nurturing attitudes towards caregiving, $\Delta R^2 = .006$, $F(1, 199) = 1.538$ $p > .05$. In the final step of

the regression analysis, the second interaction term between ethnicity (Hispanic) and generation

was entered, this step also did not account for any variance in nurturing attitudes towards

caregiving, $\Delta R^2 = .002$, $F(1, 198) = .485$ $p > .05$. At each step of this regression analysis,

predictors did not explain additional unique variance in the dependent variable.

Table 11

Summary of hierarchical regression analysis for having a nurturing attitude towards caregiving with generation as a moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.32	.10	.23**	.31	.10	.22**	.33	.10	.24**	.31	.10	.22**	.31	.10	.22**
Neuroticism	.05	.05	.07	.07	.05	.09	.05	.05	.07	.04	.05	.05	.04	.05	.05
Openness	.14	.06	.16*	.13	.06	.15*	.09	.06	.11	.09	.06	.11	.10	.06	.11
Social Support	.13	.03	.29**	.13	.03	.30**	.13	.03	.31**	.13	.03	.30**	.13	.03	.30**
Values Purity	.12	.15	.05	.12	.15	.05	.10	.15	.05	.13	.15	.06	.13	.15	.06
Predictor															
African American				1.91	.92	.15*	1.72	.91	.14	.83	1.16	.07	.54	1.24	.04
Hispanic				.89	.90	.07	.80	.90	.07	.79	.89	.06	.21	1.22	.02
Moderator															
Generation							-1.72	.80	-.15*	-2.33	.94	-.20*	-2.88	1.23	-.25*
Interaction															
African American* Generation										2.06	1.66	.12	2.62	1.85	.15
Hispanic* Generation													1.26	1.81	.07
R	.384			.407			.430			.437			.439		
R2	.148			.166			.185			.191			.193		
R2 Change	.148			.018			.019			.006			.002		
F for change in R2	7.039**			2.170			4.635*			1.538			.485		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Nurturing attitude and familism as moderator. The following regression analysis looked at familism as a moderator in the relationship between ethnicity and a nurturing attitude towards caregiving (Table 12). After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of familism was entered into the third step of the regression. The moderator variable accounted for a significant amount of additional variance in nurturing attitudes towards caregiving, $\Delta R^2 = .125$, $F(1, 200) = 35.41$, $p < .01$. The fourth step of the regression included the interaction term between ethnicity (African American) and familism. Step four was not significant, $\Delta R^2 = .000$, $F(1, 199) = .068$ $p > .05$. In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and familism was entered and also did not account for any variance in nurturing attitudes towards caregiving, $\Delta R^2 = .000$, $F(1, 198) = .038$ $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 12

Summary of hierarchical regression analysis for having a nurturing attitude towards caregiving with familism as a moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.32	.10	.23**	.31	.10	.22**	.20	.09	.14*	.20	.09	.14*	.20	.09	.14*
Neuroticism	.05	.05	.07	.07	.05	.09	.04	.05	.05	.04	.05	.05	.04	.05	.05
Openness	.14	.06	.16*	.13	.06	.15*	.16	.05	.19**	.16	.05	.19**	.16	.05	.19**
Social Support	.13	.03	.29**	.13	.03	.30**	.09	.03	.20**	.09	.03	.20**	.09	.03	.20**
Values Purity	.12	.15	.05	.12	.15	.05	.17	.14	.07	.16	.14	.07	.16	.14	.07
Predictor															
African American				1.91	.92	.15*	.59	.87	.05	.59	.88	.05	.62	.89	.05
Hispanic				.89	.90	.07	-.16	.85	-.01	-.13	.87	-.01	-.11	.87	-.01
Moderator															
Familism							4.74	.75	.39**	4.32	.96	.37**	4.13	1.35	.36**
Interaction															
African American* Familism										.39	1.48	.02	.57	1.76	.03
Hispanic* familism													.36	1.86	.02
R	.384			.407			.540			.540			.540		
R2	.148			.166			.291			.291			.292		
R2 Change	.148			.018			.125			.000			.000		
F for change in R2	7.039**			2.170			35.41**			.068			.038		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Nurturing attitude and ethnic society immersion as moderator. We conducted an analysis to look at ethnic society immersion as a moderator in the relationship between ethnicity and a nurturing attitude towards caregiving (Table 13). After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of ethnic society immersion was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in nurturing attitudes towards caregiving, $\Delta R^2 = .001$, $F (1, 200) = .282$, $p > .05$. The fourth step of the regression analysis included the interaction term between ethnicity (African American) and ethnic society immersion. This step was not significant, $\Delta R^2 = .003$, $F (1, 199) = .811$, $p > .05$. In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and ethnic society immersion was entered and this also did not account for any variance in nurturing attitudes towards caregiving, $\Delta R^2 = .011$, $F (1, 198) = 2.614$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 13

Summary of hierarchical regression analysis for having a nurturing attitude towards caregiving with following an ethnic society as moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Control Variables															
Social Desirability	.32	.10	.23**	.31	.10	.22**	.30	.10	.22**	.30	.10	.22**	.28	.10	.20**
Neuroticism	.05	.05	.07	.07	.05	.09	.07	.05	.09	.07	.05	.09	.07	.05	.09
Openness	.14	.06	.16*	.13	.06	.15*	.13	.06	.15*	.13	.06	.15*	.13	.06	.15*
Social Support	.13	.03	.29**	.13	.03	.30**	.13	.03	.30**	.13	.03	.30**	.12	.03	.28**
Values Purity	.12	.15	.05	.12	.15	.05	.12	.15	.05	.12	.15	.05	.13	.15	.06
Predictor															
African American				1.91	.92	.15*	1.93	.92	.16*	1.87	.92	.15*	1.79	.92	.14*
Hispanic				.89	.90	.07	.97	.92	.08	.88	.92	.07	1.04	.92	.08
Moderator															
Ethnic Immersion							.22	.42	.04	-.02	.50	-.00	-.61	.62	-.10
Interaction															
African American*										.83	.92	.07	1.46	.99	.12
Ethnic Immersion															
Hispanic*													1.69	1.04	.14
Ethnic Immersion															
R	.384			.407			.409			.413			.426		
R2	.148			.166			.167			.170			.181		
R2 Change	.148			.018			.001			.003			.011		
F for change in R2	7.039**			2.170			.282			.811			2.614		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

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Nurturing attitude and dominant society immersion as a moderator. The following

regression analysis looked at dominant society immersion as a moderator in the relationship

between ethnicity and a nurturing attitude towards caregiving (Table 14). After entering the five

control variables in the first step and the dummy coded ethnicity variables in the second step, the

moderator variable of dominant society immersion was entered into the third step of the

regression. The moderator variable did not account for a significant amount of additional

variance in nurturing attitudes towards caregiving, $\Delta R^2 = .001$, $F(1, 200) = .145$, $p > .05$. The

fourth step of the regression included the interaction term between ethnicity (African American)

and dominant society immersion. Results of this step did not contribute any additional variance

to the model, $\Delta R^2 = .008$, $F(1, 199) = 1.824$, $p > .05$. However, independently the interaction

term between being African American, relative to being European American, and dominant

society immersion, explained unique variance in having a nurturing attitude towards caregiving,

$b = .26$, $t(198) = 2.007$, $p < .05$. The interaction effect was examined by separating low,

moderate, and high dominant society immersion scores. Results suggested that the strength or

nature of the relationship between being African American and having a nurturing attitude

towards caregiving strengthened as one became more immersed in the dominant society (low

dominant society immersion, $R = .032$; moderate dominant society immersion, $R = .095$, high

dominant society immersion, $R = .276$). In the final step of the regression analysis, the

interaction term between ethnicity (Hispanic) and dominant society immersion was entered.

Entering the dummy coded variable interaction with dominant society immersion did not account

for any variance in nurturing attitudes towards caregiving, $\Delta R^2 = .009$, $F(1, 198) = 2.193$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance

in the dependent variable.

Table 14

Summary of hierarchical regression analysis for having a nurturing attitude towards caregiving with following a dominant society as moderator.

Variable	Step 1			Step 2			Step 3			Step 4			Step 5		
	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β	B	$SE\ B$	β
Control Variables															
Social Desirability	.32	.10	.23**	.31	.10	.22**	.31	.10	.22**	.29	.10	.21**	.30	.10	.22
Neuroticism	.05	.05	.07	.07	.05	.09	.07	.05	.09	.06	.05	.10	.06	.05	.09
Openness	.14	.06	.16*	.13	.06	.15*	.13	.06	.14*	.13	.06	.15*	.12	.06	.14
Social Support	.13	.03	.29**	.13	.03	.30**	.13	.03	.30**	.14	.03	.31**	.13	.03	.31
Values Purity	.12	.15	.05	.12	.15	.05	.12	.15	.05	.12	.15	.05	.15	.15	.07
Predictor															
African American				1.91	.92	.15*	1.99	.94	.16*	1.89	.94	.15*	1.28	1.03	.10
Hispanic				.89	.90	.07	1.01	.96	.08	.67	.99	.05	.26	1.03	.02
Moderator															
Dominant Immersion							.38	1.01	.03	-.70	1.30	-.05	-4.10	2.63	-.29
Interaction															
African American* Dominant Immersion										2.71	2.00	.11*	6.10	3.04	.26*
Hispanic* Dominant Immersion													4.48	3.03	.21
R	.384			.407			.408			.417			.428		
R2	.148			.166			.166			.174			.183		
R2 Change	.148			.018			.001			.008			.009		
F for change in R2	7.039**			2.170			.145			1.824			2.193		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Hypothesis 2.

To test hypothesis two, which suggests that gender, generation, acculturation, and familism moderate the relationship between ethnicity and expected burden, various hierarchical multiple regressions were conducted. We were interested in how each moderator independently moderates the relationship between ethnicity and expected burden, and thus this relationship was investigated for each moderator separately.

Expected burden and gender as a moderator. The first regression analysis looked at gender as a moderator in the relationship between ethnicity and expected burden (Table 15). In the first step, five control variables were entered: social desirability, neuroticism, openness, social support, and values purity. These variables accounted for a significant amount of variance in expected burden, $R^2 = .165$, $F (5, 203) = 8.035$, $p < .01$. Although openness, social support, and values purity were not significant predictors, social desirability, $b = -.15$, t(203) = -2.142, $p < .05$, and neuroticism, $b = -.33$, $t (203) = 4.683$, $p < .01$, were significant predictors of expected burden. Ethnicity scores were entered in the second step. Entering ethnicity did not significantly add to the amount of variance accounted for, $\Delta R^2 = .012$, $F (2, 201) = 1.519$, $p > .05$. Next, the moderator variable of gender was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in expected burden, $\Delta R^2 = .000$, $F (1, 200) = .019$ $p > .05$. The fourth step included the interaction term between the variable ethnicity (African American) and gender. This step was not significant, $\Delta R^2 = .003$, $F (1, 199) = .725$, $p > .05$. In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and gender was entered, and this also did not account for any variance in expected burden, $\Delta R^2 = .001$, $F (1, 198) = .137$, $p > .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 15

Summary of hierarchical regression analysis for expected burden with gender as a moderator.

Variable	Step 1 B	SE B	β	Step 2 B	SE B	β	Step 3 B	SE B	β	Step 4 B	SE B	β	Step 5 B	SE B	β
Control variables															
Social Desirability	-.59	.28	-.15*	-.56	.28	-.14*	-.55	.28	-.14*	-.56	.28	-.14*	-.56	.28	-.14*
Neuroticism	.69	.15	.33**	.71	.15	.34**	.72	.15	.34**	.72	.15	.34**	.72	.16	.34**
Openness	-.02	.17	-.01	-.02	.17	-.01	-.02	.17	-.01	-.01	.17	-.00	.000	.17	.000
Social Support	.06	.08	.04	.05	.08	.04	.05	.09	.04	.05	.09	.04	.05	.09	.04
Values	-.33	.43	-.05	-.35	.43	-.05	-.34	.44	-.05	-.35	.44	-.05	-.36	.44	-.06
Predictor															
African American				-1.64	2.64	-.05	-1.64	2.65	-.05	1.37	4.42	.04	.61	4.88	.02
Hispanic				-4.51	2.60	-.13	-4.57	2.64	-.13	-4.36	2.65	-.12	-5.69	4.47	-.16
Moderator															
Gender							-.33	2.37	-.01	.98	2.82	.03	-.03	3.92	-.00
Interaction															
African American* Gender										-4.29	5.04	-.11	-3.27	5.75	-.08
Hispanic*Gender													2.06	5.57	.05
R	.406			.421			.422			.425			.426		
R2	.165			.178			.178			.181			.181		
R2 Change	.165			.012			.000			.003			.001		
F for change in R2	8.035**			1.519			.019			.725			.137		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Expected burden and generation as a moderator. We looked at generation as a

moderator in the relationship between ethnicity and expected burden (Table 16). After entering

the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of generation was entered into the third step of the regression. This did not account for a significant amount of additional variance in expected burden, $\Delta R^2 = .001$, $F (1, 200) = .162$, $p > .05$. The fourth step of the regression looked at the interaction between ethnicity (African American) and generation. This step was not significant, $\Delta R^2 = .000$, $F (1, 199) = .003$, $p > .05$. In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and generation was entered. Entering the dummy coded variable interaction with generation accounted for variance in expected burden, $\Delta R^2 = .024$, $F (1, 198) = 5.995$, $p < .05$. The interaction effect was examined separately. Results suggested the strength or the nature of the relationship between being Hispanic, as opposed to being European American, and expected burden, was higher for middle-aged adults ($R = .23$) when compared to young adults ($R = .19$). At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 16

Summary of hierarchical regression analysis for expected burden with generation as a moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β
Control variables															
Social Desirability	-.59	.28	-.15*	-.56	.28	-.14*	-.55	.28	-.14*	-.57	.28	-.14*	-.56	.28	-.14*
Neuroticism	.69	.15	.33**	.71	.15	.34**	.72	.15	.34**	.72	.15	.34**	.75	.152	.35**
Openness	-.02	.17	-.01	-.02	.17	-.01	.02	.17	.00	.00	.17	.00	-.04	.173	-.02
Social Support	.06	.08	.04	.05	.08	.04	.05	.08	.04	.05	.09	.04	.07	.09	.06
Values	-.33	.43	-.05	-.35	.43	-.05	-.34	.43	-.05	-.34	.44	-.05	-.33	.44	-.05
Predictor															
African American				-1.64	2.64	-.05	-1.54	2.66	-.04	-1.65	3.40	-.05	1.28	3.57	.04
Hispanic				-4.51	2.60	-.13	-4.47	2.61	-.12	-4.47	2.62	-.12	1.37	3.52	.04
Moderator															
Generation							.93	2.32	.03	.86	2.75	.03	6.43	3.55	.19
Interaction															
African American* Generation										.25	4.86	.00	-5.48	5.34	-.11
Hispanic* Generation													-12.72	5.21	-.26*
R	.406			.421			.422			.422			.450		
R2	.165			.178			.178			.178			.202		
R2 Change	.165			.012			.001			.000			.024		
F for change in R2	8.035**			1.519			.162			.003			5.955*		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Expected burden and familism as a moderator. The following regression analysis looked at familism as a moderator in the relationship between ethnicity and expected burden (Table 17).

After entering the five control variables in the first step and the dummy coded ethnicity variables in the second step, the moderator variable of familism was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in expected burden, $\Delta R^2 = .012$, $F(1, 200) = 2.935$, $p > .05$. The fourth step of the regression included the interaction between ethnicity (African American) and familism, and this step was significant, $\Delta R^2 = .044$, $F(1, 199) = 11.528$, $p < .05$. Independently the interaction term between African American, relative to European American, and familism, was significant, $b = .28$, $t(199) = 3.395$, $p < .01$. The interaction effect was examined by separating low, moderate, and high familism scores. Results suggested that the strength or nature of the relationship between being African American and expecting burden was less for those with moderate familism ($R = .078$), slightly higher for low familism ($R = .176$), and the highest for high familism ($R = .261$). In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and familism was entered, but this step did not account for variance in expected burden, $\Delta R^2 = .011$, $F(1, 198) = 2.856$, $p < .05$. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 17

Summary of hierarchical regression analysis for expected burden with familism as moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β
Control variables															
Social Desirability	-.59	.28	-.15*	-.56	.28	-.14*	-.46	.28	-.12*	-.42	.27	-.11*	-.44	.27	-.11*
Neuroticism	.69	.15	.33**	.71	.15	.34**	.74	.15	.35**	.70	.15	.33**	.69	.15	.33**
Openness	-.02	.17	-.01	-.02	.17	-.01	-.05	.17	-.02	-.03	.16	-.01	-.03	.16	-.01
Social Support	.06	.08	.04	.05	.08	.04	.09	.09	.07	.08	.09	.07	.08	.09	.07
Values	-.33	.43	-.05	-.35	.43	-.05	-.39	.43	-.06	-.56	.42	-.08	-.57	.42	-.09
Predictor															
African American				-1.64	2.64	-.05	-.47	2.71	-.01	-.73	2.65	-.02	.04	2.67	.00
Hispanic				-4.51	2.60	-.13	-3.58	2.65	-.10	-2.14	2.61	-.06	-1.76	2.61	-.05
Moderator															
Familism							-4.00	2.33	-.12	-10.17	2.91	-.30**	-14.92	4.04	-.44**
Interaction															
African American* Familism										15.14	4.46	.28**	19.91	5.26	.37**
Hispanic* Familism													9.42	5.57	.15
R	.406			.421			.435			.484			.495		
R2	.165			.178			.190			.234			.245		
R2 Change	.165			.012			.012			.044			.011		
F for change in R2	8.035**			1.519			2.935			11.528**			2.856		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Expected burden and ethnic society immersion as moderator. We looked at immersion in

ethnic society as a moderator in the relationship between ethnicity and expected burden (Table

18). After entering the five control variables in the first step and the dummy coded ethnicity

variables in the second step, the moderator variable of ethnic society immersion was entered into

the third step of the regression. The moderator variable did not account for a significant amount

of additional variance in expected burden, $\Delta R^2 = .005$, $F(1, 200) = 1.107$, $p > .05$. The fourth step

of the regression analysis included the interaction between ethnicity (African American) and

ethnic society immersion. This step was not significant, $\Delta R^2 = .000$, $F(1, 199) = .023$, $p < .05$.

In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and

ethnic society immersion did not account for variance in expected burden, $\Delta R^2 = .003$, $F(1, 198)$

$= .734$, $p < .05$. At each step of this regression analysis, predictors did not explain additional

unique variance in the dependent variable.

Table 18

Summary of hierarchical regression analysis for expected burden with following an ethnic society as moderator.

	Step 1			Step 2			Step 3			Step 4			Step 5		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Control variables															
SD	-.59	.28	-.15*	-.56	.28	-.14*	-.52	.28	-.13	-.52	.28	-.13	-.49	.28	-.12
Neuroticism	.69	.15	.33**	.71	.15	.34**	.71	.15	.33**	.70	.15	.33**	.70	.15	.33**
Openness	-.02	.17	-.01	-.02	.17	-.01	-.03	.17	-.01	-.03	.17	-.01	-.03	.17	-.01
SS	.06	.08	.04	.05	.08	.04	.05	.08	.04	.05	.09	.04	.07	.09	.05
Values	-.33	.43	-.05	-.35	.43	-.05	-.37	.43	-.06	-.37	.44	-.06	-.39	.44	-.06
Predictor															
African American				-1.64	2.64	-.05	-1.79	2.64	-.05	-1.76	2.65	-.05	-1.63	2.66	-.05
Hispanic				-4.51	2.60	-.13	-4.98	2.64	-.14	-4.94	2.66	-.14*	-5.19	2.68	-.14*
Moderator															
Ethnic Immersion							-1.27	1.21	-.07	-1.16	1.43	-.06	-.24	1.79	-.01
Interaction															
African American* Ethnic Immersion										-.40	2.65	-.01	-1.37	2.88	-.04
Hispanic* Ethnic Immersion													-2.59	3.03	-.07
R	.406			.421			.427			.427			.430		
R2	.165			.178			.182			.182			.185		
R2 Change	.165			.012			.005			.000			.003		
F for change in R2	8.035**			1.519			1.107			.023			.734		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

Expected burden and dominant society immersion as a moderator. The following

regression analysis looked at dominant society immersion as a moderator in the relationship

between ethnicity and expected burden (Table 19). After entering the five control variables in the

first step and the dummy coded ethnicity variables in the second step, the moderator variable of "dominant society immersion" was entered into the third step of the regression. The moderator variable did not account for a significant amount of additional variance in expected burden, ΔR^2 =.008, F (1, 200) = 2.081, p > .05. The fourth step of the regression included the interaction term between ethnicity (African American) and dominant society immersion. This step was not significant, ΔR^2 =.007, F (1, 199) = 1.720, p > .05.   In the final step of the regression analysis, the interaction term between ethnicity (Hispanic) and dominant society immersion was entered and this did not account for variance in expected burden, ΔR^2 = .002, F (1, 198) = 415, p < .05. At each step of this regression analysis, predictors did not explain additional unique variance in the dependent variable.

Table 19

Summary of hierarchical regression analysis for expected burden with following a dominant society as moderator.

Step 1	Step 2	Step 3	Step 4	Step 5

Variable	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β	B	SE B	β
Control variables															
Social Desirability	-.59	.28	-.15*	-.56	.28	-.14*	-.54	.28	-.14*	-.50	.28	-.13	-.51	.28	-.13
Neuroticism	.69	.15	.33**	.71	.15	.34**	.70	.15	.33**	.70	.15	.33**	.69	.15	.33**
Openness	-.02	.17	-.01	-.02	.17	-.01	.05	.17	.02	.04	.17	.02	.05	.17	.02
Social Support	.06	.08	.04	.05	.08	.04	.06	.08	.04	.05	.08	.04	.05	.09	.04
Values	-.33	.43	-.05	-.35	.43	-.05	-.40	.43	-.06	-.38	.43	-.06	-.43	.44	-.06
Predictor															
African American				-1.64	2.64	-.05	-2.55	2.71	-.07	-2.26	2.71	-.06	-1.50	2.96	-.04
Hispanic				-4.51	2.60	-.13	-5.88	2.76	-.16*	-4.92	2.85	-.14*	-4.41	2.96	-.12*
Moderator															
Dominant Immersion							-4.17	2.89	-.10	-1.15	3.69	.03	3.12	7.59	.08
Interaction															
African American*Dominant Immersion										-7.54	5.75	-.11	-11.79	8.76	-.17
Hispanic*Dominant Immersion													-5.62	8.73	-.09
R	.406			.421			.431			.439			.441		
R2	.165			.178			.186			.193			.195		
R2 Change	.165			.012			.008			.007			.002		
F for change in R2	8.035**			1.519			2.081			1.720			.415		

Note: Overall Fit Statistics for Each Step; *p<.05, **p<.01.

CHAPTER 4

Discussion

The central goals of this study were to investigate ethnic and generational differences in individuals' attitudes towards caregiving for an older parent, and the expected burden of this caregiving experience. First, descriptive statistics were conducted. Second, hypotheses were tested via ANOVAs, t-tests, and moderation analyses investigating the moderating effects of variables of interest on the relationship between ethnicity and generation, with attitudes towards caregiving and expected burden.

Results demonstrated significant generational differences in attitudes towards caregiving, with younger adults reporting having a more nurturing attitude towards caregiving when compared to their middle-aged adult counterparts. Having a nurturing attitude towards caregiving refers to the caregiver's belief that his or her role as a caregiver is to provide care in the most comfortable and effective way. Research has demonstrated that caregiver and care receiver relationships are described as good relationships when the caregiver follows a nurturing attitude (Phillips et al., 1989). In contrast having a monitoring attitude towards caregiving refers to the caregiver's belief that she or he must control the care receiver's behavior, regardless of the consequences. Having a monitoring attitude has been found to be associated with "extreme," forms of behavior, including forms of behaviors that would be considered as adult physical abuse (Phillips, et al., 1989). Previous studies have demonstrated similar findings with regards to generational differences in their views about caregiving. Brody et al., (1983) found that young adult women, when compared to their middle-aged and older adult counterparts, experience, in general, no ambivalence when faced with having to provide care for an older adult family member. Additionally, they expressed more empathy towards filial and grandfilial responsibility when it came to their attitudes towards taking care of an older adult family member. Although these results do not specifically align with the result of this dissertation, we can interpret Brody's

results in the context of a nurturing attitude, as these young adults appear to have no doubts about providing care for an older family member and providing adequate care that instills a good relationship. These results may be due to young adults being more removed from having to take care of their parents than the middle-aged adult group, who may already be anticipating this responsibility. Additionally, middle-aged adults are in a predicament with an increasing aging population and a generation of young adults experiencing difficulties in achieving financial independence from their parents. Approximately half of middle-aged adults have an older adult parent that they are caring for and are raising children or providing financial assistance to a grown child (Parker & Patten, 2013); these individuals who are caring for their aging parents while caring for their children are called the sandwich generation. Although our group of middle-aged adults were, at the time, not looking after their parents, it is possible that the anticipation of being part of the sandwich generation in the near future may have caused them to have a less nurturing attitude towards taking care of their parents.

Similarly, when investigating gender differences in attitudes towards caregiving, results indicated that females tend to demonstrate more of a nurturing attitude towards caregiving when compared to males. In general, there is a hierarchy in the selection of the primary caregiver. The first determinant when it comes to choosing a primary caregiver is sex, with females tending to provide more care than males (Laditka, 2000; Montgomery et al., 2007). Approximately fifty percent of middle-aged women with a parent still living become adult caregivers at some point in their lives (Himes, 1994). Sons tend to "step up to the plate" only in the absence of a female sibling, and many times it is the spouse of a son that becomes the primary caregiver for that son's parents (Horowitz, 1985). These results fit the stereotype regarding people's beliefs that women are more nurturing in their care and take on this responsibility before men do. However,

other research has also found no differences between females and males in nurturing when it comes to child care (Coltrane, 1996; Rishman, 1998). Although we see more women taking on the role of the caregiver, research has also shown the same for males (Bond et al., 2003). It is possible that the discrepancy in these results is due to differences in methodology or changes in society's values.

When researching ethnic differences in ethnic society immersion, European Americans reported higher ethnic society immersion than Hispanics. Ethnic society immersion refers to how much one immerses himself or herself into an ethnic society (for example, African American, Hispanic, etc.), regarding the language one chooses to speak, the ethnicity of the individuals one chooses to interact with, the food one chooses to eat, and the media one chooses to follow. Similarly, when investigating ethnic differences in dominant society immersion, European Americans reported higher dominant society immersion when compared to African Americans and Hispanics. Dominant society immersion refers to how much one chooses to immerse oneself into the dominant society (American society) with regards to language, interacting with people, food, and media. With regards to differences where European Americans report higher ethnic and dominant society immersion than the two minority groups, these results may be due to European Americans' length of time living in the United States. It is possible that European Americans answered the ethnic society immersion questions as if they were answering dominant society immersion questions, since they may not be as used to reflecting on their ethnicity and immersion to dominant culture as minority groups are. For example, to questions such as "I know how to speak my native language," "I regularly read magazines of my ethnic group," and other items, they may have interpreted them as though they were items referring to the dominant society. Their interpretation of these items could also be due to a lack of knowledge regarding

their ethnic heritage. Another explanation for these results could be the limitations of the SMAS, which may be more useful for newer European American immigrants of the first and second generations (Stephenson, 2000). In particular, regarding the results showing that European Americans reported higher dominant society immersion, this result is more consistent with the general acculturation literature which demonstrates that third and fourth generation minority individuals differ from third and fourth generation nonminorities (Stephenson, 2000). Regardless of the number of generations lived in the United States, minorities continue to be minorities, and respond to items differently from majority individuals. This difference in performance between minority and majority individuals emphasizes the need for further research into the understanding of acculturation experiences. Regarding the acculturation scale, generational differences in ethnic society immersion were also found, with middle-aged adults reporting higher ethnic society immersion than younger adults. One explanation for this result is that middle-aged adults are less acculturated than younger adults. This could be a function of generational status and/or time of immigration, as well as young adults currently being in college and the influence of college on one's level of acculturation (Fiebeg, Braid, Ross, Tom, & Prinzo, 2010).

Regarding ethnic differences in familism, results demonstrated ethnic differences on all subscales of the familism scale. First, results demonstrated that African Americans report more familial support and more familial interconnectedness than European Americans. Lugo-Steidel and Contreras (2003) refer to familial support as the idea that one has the obligation to offer support (for example, emotional, financial) to family members, despite the circumstances. Familial interconnectedness is referred to as maintaining physical and emotional closeness with family members. Second, it was found that Hispanics reported more familial honor than

European Americans. By familial honor, Lugo-Steidel and Contreras (2003) refer to the obligation of upholding the family name. Third, the subscale Subjugation of Self was found to be higher in African Americans and Hispanics when compared to European Americans. Subjugation of self refers to accepting that each individual within a family system must be submissive and yield to the family (Lugo-Steidel & Contreras, 2003). Overall, familism was found to be higher for African American and Hispanics when compared to European Americans. Similar findings have been reported by other researchers when comparing different ethnic groups to European Americans, with other ethnic groups, including Hispanics, African Americans, and Asians, following more familistic values and traditions than European Americans (Sabogal, Marin, Oter-Sabogal, Marin, & Perez-Stable, 1987; Landale, Oropesa, & Bradatan, 2006; Desmond & Turley, 2009).

In contrast, research has also demonstrated no differences in familism amongst the three different ethnic groups examined in this study. In a study of African American, European American, and Hispanic adolescents, Forbes (2000) did not find any differences in levels of familism amongst adolescents from these three groups. These discrepancies could be due to research methodology, such as these individuals being adolescents. It is possible that these adolescents were second, third, or fourth generation, and thus more acculturated. As argued by Landale et al. (2006), assimilation reduces familism, and this can mostly be seen in subsequent generations. Similarly Schwartz, (2007) found familism operating similarly within different ethnic groups. Interestingly, generational differences were not observed. It is possible that familism is a construct that either remains constant as one ages or that does not depend on one's cohort.

Control Variables and Ethnicity as a Predictor

From the control variables entered in Hypothesis 1A (monitoring attitude), neuroticism was found to be a significant predictor of having a monitoring attitude towards caregiving. This suggests that people who reported having high levels of neuroticism also tend to have a monitoring attitude towards caregiving. Individuals with a monitoring attitude towards caregiving tend to control the care receiver's behavior using any means necessary (Phillips et al, 1989). In general, people with high levels of neuroticism tend to perceive more impairment and more problem behaviors in the care receiver (Bookwala, 1996; Bookwala & Sculz, 1998).

After controlling for different variables of interest, the predictor of ethnicity was entered into the second step in Hypothesis 1A. Results demonstrated that African Americans, when compared to European Americans, had greater monitoring attitudes towards caregiving. Although there is not much research on these attitudes towards caregiving and the concept of monitoring, research on the caregiving provided by African Americans has demonstrated mixed findings. A qualitative study investigating African American caregivers of a family member with dementia found the following themes: obligation, resignation, enduring, need for specialized resources, loss, manager, emotional detachment, behavioral symptoms of dementia, role conflict, church, family, reciprocity, and reflection (Henry-Edwards, 2014). In contrast, Bennet, Sheridan, and Richardson (2014) found that African Americans' care approach included consideration of caregiving as an honor and blessing, a part of their identity, being sustained by having a personal relationship with God, and being a calling from God.

From the control variables entered in Hypothesis 1B (nurturing attitude), social desirability, openness, and social support were found to be significant predictors of having a nurturing attitude towards caregiving. This suggests that people who reported having high levels

of social desirability, openness, and social support also reported having a nurturing attitude towards caregiving.

Interestingly, when it came to investigating whether ethnicity predicted attitudes towards caregiving, being African American, rather than European American, predicted both having a monitoring and a nurturing attitude towards caregiving. These results are in line with the previous research reported under Hypothesis 1A suggesting results along a caregiving continuum from monitoring to nurturing in African Americans. It is possible that African Americans demonstrate both forms of atittudes towards caregiving due to different cultural mechanisms. Sheridan, Burley, Hendricks, and Rose (2014) found that, on average, African American caregivers of older adults report time-dependence, financial burden, little social and physical burden, low levels of support, little emotional and relationship distress, high levels of caregiving reward, high religion, and spirituality. They explain this variability as indicative of the multifaceted and diverse experience that caregiving can be for African Americans.

For Hypothesis 2, the control variables of social desirability and neuroticism were found to be significant predictors of expecting burden. Results specifically indicated that individuals with higher social desirability and high levels of neuroticism tend to expect more burden when anticipating being in a caregiving role.

Second, the predictor of ethnicity was entered into the second step. Results did not suggest ethnicity predicting an expectation of burden when controlling for the control variables. Interestingly, previous research that has investigated the differences between being African American and European American on the experience of burden, research has demonstrated that African Americans report less psychological distress when compared to their European American counterparts (Miles, 2003). The indication that there is not an association between

ethnicity and expected burden may suggest these individuals are not actively thinking of what caregiving will look like or what they could expect.

Moderator Variables

Moderator variables were entered in the third step of each hypothesis. For Hypothesis 1A and Hypothesis 2, no moderator (gender, generation, familism, and acculturation) main effects were found on having a monitoring attitude towards caregiving and expected burden. When it comes to the dependent variable of monitoring attitudes towards caregiving, the lack of moderator main effects may be a result of what having a monitoring attitude towards caregiving means. Since having a monitoring attitude towards caregiving suggests that the caregiver exerts control over the patient a possible reason for lack of main effect in these variables may be due to other variables not considered in the study such as love and respect for an older parent across the different moderator variables. When it comes to the dependent variable of expected burden, an ethnicity by generation interaction and an ethnicity by familism interaction were found which will be discussed later in this chapter. However, neither main effects nor interactions were found for gender and acculturation, suggesting no gender differences and no acculturation differences when it comes to the expectation of burden. In regard to gender, it is possible that other variables, such as number of responsibilities could shed light on gender differences. Regarding acculturation and whether one is more or less inclined to follow the dominant versus ethnic society or vice versa, it may be the case that the meaning of caregiving and caregiving experiences are the same across cultures.

For Hypothesis 1B, the first moderator investigated was gender. Gender was found to have a main effect, with females tending to have a higher nurturing attitude when compared to

males. This gender difference may be due to the tendency for females to take on the caregiving role. As it has been previously mentioned, the first one to take on the caregiving role is usually a spouse and after that a daughter or daughter-in-law. However, although there is a trend of females providing more care than males, this trend is changing due to the increase in older adults requiring care and changing sex roles within the family (Hansen & Slagsvold, 2014; Schwartz, 2014).

The second moderator investigated in Hypothesis 1B was generation. Generation was found to have a main effect on nurturing attitudes towards caregiving, with young adults reporting a higher nurturing attitude than middle-aged adults. One possible reason for this may be due to young adults being far removed from having to take on this responsibility and middle-age adults' anticipation of having to care for their parents in the near future. It may be the case that middle-age adults have more access to other individuals who have gone through the caregiving experience and may be more knowledgeable about resources available for caregivers. As mentioned previously, Brody et al. (1983) found that young adult women, when compared to their middle-aged and older adult counterparts, experience, in general, no ambivalence when faced with having to provide care for an older adult family member. In contrast, Troll (1986) found that young adults tend to resent having to care for an older adult, but they rarely think of not doing it.

The third moderator investigated in Hypothesis 1B was familism. Familism was also found to have a main effect on nurturing attitudes towards caregiving, with individuals reporting higher levels of familism also reporting having a higher attitude towards nurturing. Familism suggests that the family unit is more important than the individual and thus this increasing one having a nurturing attitude may be explained to the importance one sees in family members and

maintaining a family unit. Similarly, Toro (2011) found associations between low familism and low nurturing with regards to parenting. No main effects were found for the subscales of acculturation.

Interactions

Interaction terms were entered in the fourth and fifth step of each hypothesis. For Hypothesis 1A, no interactions were found between ethnicity and the different moderators (gender, generation, familism, and acculturation) on monitoring attitudes towards caregiving. This suggests that the moderator variables of gender, generation, familism, and acculturation did not impact the strength of the relationship between ethnicity and monitoring attitudes towards caregiving. It is possible that when it comes to the comparison between individuals that are Hispanic or European American, these variables did not impact the relationships because there was no relationship to begin with. When it comes to being African American, which was found to predict having a monitoring attitude, there was no effect of an individual's gender, generation, familism, or acculturation.

For Hypothesis 1B, an interaction between being African American, as opposed to European American, and following a dominant society, was found in the relationship between ethnicity and having a nurturing attitude towards caregiving. In other words, the strength or nature of the relationship between being African American and having a nurturing attitude towards caregiving strengthened as one became more immersed in the dominant society. It is possible that African Americans' views about someone in need of care change as one is more acculturated, and this acculturation influences one's views towards nurturing rather than monitoring (McCallion, Janicki, & Grant-Griffin, 1997). No interactions were found between the

relationship of being African American and having a nurturing attitude, and being Hispanic and having a nurturing attitude, for the other moderator variables. This suggests that the variables of gender, generation, familism, and following an ethnic society did not impact the strength in which some ethnicities follow or do not follow a nurturing attitude. This means that following a nurturing attitude is not dependent on gender, generation, familism attitudes, or following an ethnic society.

For Hypothesis 2, an interaction between generation and ethnicity was found. This interaction indicated that expected burden changed as a function of generation, with young adults expecting less burden than middle-aged adults in Hispanics, but not in African Americans, when compared to European Americans. It is possible that these results are due to middle-aged Hispanics' observation of other middle-aged Hispanics' experience with caregiver burden. Another important interaction was that seen between familism and ethnicity on expected burden. Results indicated that the strength or nature of the relationship between being African American, as opposed to European American, and expecting burden was less for those with moderate familism, slightly higher for low familism, and the highest for high familism. Previous research on familism, caregiving, and burden has suggested that familism is not a protective factor against burden, possibly due to familism increasing the perception of an obligation towards caregiving rather than providing care because one desires to provide that care (Knight & Sayegh, 2010). This research has mostly been observed with Hispanics, but it is possible that something similar could be happening with African Americans, with those with moderate levels of familism expecting less burden, and those with low and high familism expecting higher levels of burden due to being at the ends of the continuum of familism. No interactions were found between

gender or acculturation, and ethnicity. This suggests that expected burden does not change as a function of gender on ethnicity and/or acculturation and ethnicity.

Summary

Overall, when examining descriptive statistics on the different variables, results were as expected and as demonstrated by previous research. When talking about gender and generation, females and younger adults reported having a higher nurturing attitude towards caregiving. These results confirm females' tendency to undertake the caregiving role, accept such caregiving role, and provide nurturing care. These results also confirm that young adults have a better attitude to caregiving when compared to middle-aged adults. As mentioned above, this may be due to middle-aged adults anticipating this experience in the near future.

When discussing acculturation, European Americans reported significantly more ethnic society immersion as well as dominant society immersion. Regarding these results, it may be the case that this group scored higher on ethnic society immersion and dominant society immersion due to their culture and generational level, with their ethnic society immersion being very similar to their dominant society immersion. Descriptive statistics regarding familism were as expected with Hispanics and African Americans reporting significantly higher familism than European Americans. This result suggests that these two groups emphasize the family more, and at times these individuals go to great length to place the family before the individual, something perhaps European Americans coming from an individualistic culture would not do.

Regarding main effects, as expected and as mentioned above, main effects of gender, generation, and familism were found, having an effect on nurturing attitude towards caregiving.

Results suggested females, younger adults, and individuals reporting higher familistic values endorse having a nurturing attitude towards caregiving.

In regards to interactions, three interactions were found. The first interaction involved the moderating variable of dominant society. Results suggested that as African American individuals became more acculturated and more closely followed the dominant society, their attitude towards nurturing caregiving strengthened. Meaning that, as African Americans immersed themselves more into the dominant society, their nurturing attitudes increased. The second interaction found was that, amongst Hispanics and their expectation of burden, this expectation decreased for young adults. This result was not found for the African American group. The third interaction suggested the strength of the relationship between being African American and expecting burden was less for those with moderate familism, slightly higher for low familism, and highest for high familism. This supports previous research on familism, caregiving, and burden which suggests that familism is not a protective factor against burden, possibly due to familism increasing the perception of an obligation towards caregiving rather than providing care because one desires to provide that care (Knight & Sayegh, 2010).

Limitations and Future Research

This study has a number of limitations that require consideration. First is the limitation of its sample size. We sampled young-adults and middle-aged adults of three different ethnic groups (European American, African American, and Hispanic). It is important to mention that not all samples were of equal size, due to marked difficulty recruiting middle-aged African American and Hispanic adults. Difficulty recruiting minorities into research is common, and various researchers have discussed this as an issue along with possible strategies that can aid the

recruitment of minorities (Wallace & Barlett, 2013). The same difficulty was not observed with young adults because the recruitment took place in a university setting.

This study is also limited by its methodology. This study only used self-reports, which rely exclusively on the participants' judgment and interpretation of the items in the questionnaire. Furthermore, a few of the self-report measures were limited in their previous research, particularly the measure used to research people's attitudes towards caregiving. The research regarding attitudes towards caregiving is also limited, thus it is hard to say if these results are in line with previous research specific to this topic. However, as a proxy, it can be said that it is in line with the general literature on caregiving, ethnicity, and familism. Regarding the measure of acculturation, one of its limitations is that individuals from later generations (third generation and fourth generation) may experience difficulty answering some of the scale's items (Stephenson, 2000).

The cross-sectional nature of the study and correlational design limit our ability to make causal inferences. This study measured attitudes towards caregiving at a single point in time, thus limiting our understanding of how an individual's attitudes may change over time as one ages and throughout the course of a caregiving experience. Also, because this study lacks experimental control and manipulations, it limits our understanding of what causes certain attitudes towards caregiving.

Future research on individual attitudes towards caregiving might benefit from several improvements upon the current study. Although costly and time consuming, a longitudinal study can provide information regarding how much an individual's attitudes and expected burden changes over time and with experience. Results from such a research study can highlight how much one is prepared or underprepared to take on the challenging task of providing care for

someone. Although it could be recommended that a different acculturation scale that controls for generational status be used, this is the only acculturation scale that can be used across different ethnic groups. Furthermore, in general, acculturation scales are limited and thus future research should also focus on developing better acculturation measures that can assist with future research methodologies.

Implications

These findings have several different implications. Regarding the generational differences in individuals' nurturing attitude towards caregiving, the fact that younger adults reported having significantly more nurturing attitude than their middle-aged counterparts suggests their lack of awareness of how stressful and burdensome the caregiving experience can be. Education about caregiver stress is a way in which people can be made aware of the detrimental effect of taking on this role. Additionally, when it comes to middle-aged adults, preparation and conversation with their older adult parents about this time might decrease some of the burden, for instance, deciding on a nursing home, putting their names down on waiting lists, and organizing paperwork. In the event of a difficult relationship that interferes with the capacity for the middle-aged adult to provide appropriate care, family therapy might be a solution.

Similar results to previous studies were found when comparing females to males, in that females reported significantly more nurturing attitudes than males. Again, education aimed at males in order to encourage sharing the responsibility with females and highlighting how stressful the caregiving experience can be is recommended. Planning is another factor that can alleviate some of the anticipated burden.

Regarding the finding that African Americans have both nurturing and monitoring attitudes towards caregiving, African Americans' level of familism influences how much burden they expect to experience when providing care, while Hispanics' expectation of burden varies as a function of age. This information is useful because it may assist in pinpointing specific areas for health care providers to address when encountering certain ethnic groups of certain ages taking on the challenge of caregiving. These results may also assist policy makers when considering what the effect of an aging society will have at the societal level for these groups, and how some cultural values may be protective or not. Additionally, educating individuals, having individuals think about the possibilities of providing care in the future, and reflecting on what they think this care will look like is important. Many individuals are not prepared for taking on such challenges, making the experience more stressful.

Another consistent finding that has important implications as well is that of the personality trait of neuroticism being a predictor for having a monitoring attitude and expecting burden. Having a monitoring attitude can affect the relationship with the care receiver and increase stress. Awareness about one's personality traits and tendencies can help alleviate future stressful situations.

APPENDIX

Table 20.

Bivariate Pearson's correlations among the main variables of the study.

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Monitoring		.101	.248**	-.059	-.025	.122	.018	-.083	.026	.170*	-.048	.042	-.107
2. Nurturing			-.153*	.182**	-.172*	.435**	.056	.060	.168*	-.032	.192**	.266*	.096
3. Expected Burden				.042	-.045	-.139*	-.100	-.075	-.264**	.373**	.008	.023	-.071
4. Gender					.023	.030	.103	.112	.074	.146*	-.034	.026	.098
5. Generation						-.100	.208**	.120	.133	-.185**	-.310**	.008	-.084
6. Familism							-.027	-.016	.163*	-.020	-.067	.189**	-.057
7. Ethnic Immersion								.327**	.117	-.128	-.050	.064	-.022
8. Dominant Immersion									.026	-.087	.225**	.108	-.012
9. Social Desirability										-.336**	-.002	-.135	.009
10. Neuroticism											.066	-.111	-.068
11. Openness												.081	.167*
12. Social Support													.076
13. Values Purity													

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