2017

Filipino Americans' Perspectives on Caregiving

Maribel Lapuos Dominguez
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Maribel Dominguez

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Robin Friedman, Committee Chairperson, Psychology Faculty
Dr. Kathryn Dardeck, Committee Member, Psychology Faculty
Dr. Georita Frierson, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Filipino Americans' Perspectives of Caregiving

by

Maribel Lapuos Dominguez

MS, Walden University, 2011

BA, University of the Philippines, 1993

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Psychology

Walden University
May 2017

Abstract

With increased life expectancy, more individuals will need to rely on caregivers and/or caregiving services. Filipino Americans are reluctant to depend on outside help when it comes to caring for their family members. There was a gap in the literature concerning the specific impact of the caregiving role on Filipino Americans and how cultural values affect the care provided to their family members. The purpose of this qualitative study was to gain understanding of how Filipino cultural values and life roles affected Filipino Americans' experiences of caregiving. The conceptual framework included the sociocultural stress and coping model. The central research question for the study was used to explore the personal impact of caregiving for Filipino Americans and the sociocultural factors affecting this role. A phenomenological research design guided the data collection and analysis process. Individual, semistructured interviews were conducted with 8 participants, recruited from several Catholic Church groups and Filipino community groups located in the Southwestern region of Houston, Texas. Data were analyzed using Moustakas' steps for phenomenological data analysis and 7 themes were identified: responsibility of caregiving, impact of caregiving on employment status, impact and importance of religion to caregivers, impact of Filipino heritage on caregivers, impact of care recipient's illness on the caregiver and recipient, resources for caregivers, and reflections on the caregiver experience. Filipino Americans are unique in their practices to provide care for their family members rather than relying on outside providers and institutions. This study may result in positive social change by understanding how societal supports can encourage a model of care based on cultural and familial values rather than outside institutional care.

Filipino Americans' Perspectives of Caregiving

by

Maribel Lapuos Dominguez

MS, Walden University, 2011

BA, University of the Philippines, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

May 2017

Dedication

To Jed: Thank you for being both mommy and daddy for the longest time, while I worked to complete my “third baby”.

To Bianca: Thank you for loving your baby brother and stepping in whenever you could to help out at home.

To Jelo: Thank you, baby, for simply being you! Thank you for staying up to keep mommy company even though you really had to sleep. Please don’t do that ever again. Have mercy on your dad.

Acknowledgments

Thank you, Dr. Friedman! Without your help and endless patience, I could not have accomplished this without you. Thank you for all your guidance and for sticking with me throughout this process!

Thank you, Dr. Dardeck! Thank you for your guidance and patience. I could not have accomplished this without your help either! Thank you too for seeing this process to the end with me!

To all participants of this research study, thank you for your time and your graciousness in allowing me to interview you in what may be one of the most difficult times in your lives thus far. Without you, this project may have never been completed.

Table of Contents

Chapter 1: Introduction to the Study

Across countries and cultures, aging has been associated with an increase in the prevalence of chronic illnesses (Varona, Saito, Takahashi, & Kai, 2007). Older adults with chronic illnesses may be more dependent on others. As Varona et al. (2007) have noted, the need for caregivers and caregiver services has increased in this context. The number of caregivers has increased over time. In the United States, this number has increased from approximately 36.5 million caregivers in 2008, to approximately 67.5 million caregivers in 2009 (National Alliance for Caregiving, 2009).

Although researchers have found evidence of the association between caregiving and a sense of personal satisfaction and achievement, they have also found it to be associated with decreased contact with social support networks, difficulty prioritizing demands, and decreased stress resilience (Scheidegger, Lovelock, & Kinebanian, 2010). Caregivers have also noted a deterioration in their physical or mental health as evidenced by higher stress and depression as well as increased feelings of burden (Collins & Swartz, 2011). Some caregivers experience financial hardship because they must reduce or give up full-time employment in order to provide reliable, uninterrupted care to a chronically or seriously ill family member (Scheidegger et al., 2010). The American Psychological Association (APA) addressed these concerns in a 2011 resolution on caregiving. In the resolution, the organization recognized the potential for family caregivers to experience considerable stress, strain, burden, and disruption of their own lives, specifically in areas such as health, employment, social, and intellectual pursuits (APA, 2011). With the number of caregivers increasing, there is a need for more studies that focus on Filipino

American caregivers. Results of these studies can provide added insight into factors that may either add to or alleviate caregiver burden and affect the caregiver experience.

In this study, I focused on Filipino American caregivers’ experiences of the caregiving role. This study may result in positive social change by increasing individual caregivers’ awareness of how sociocultural factors such as Filipino cultural values and life roles affect their experience of caregiving. Such knowledge may provide caregivers and caregivers’ families and social support networks insights about the rewards, difficulties, and challenges of being a caregiver. From this insight, researchers may develop improved support systems for caregivers, which may lessen perceived burden and stress and improve overall caregiver health (Varona et al., 2007). When caregivers are healthy, they may be able to provide a better quality of life for those who receive their services (Varona et al., 2007). Positive social change may also result from researchers and policy makers who improve and advance policies, effective treatments, and interventions that help caregivers meet their needs as well as identify potentially effective support sources (Epiphaniou et al., 2012).

In this chapter, I provide the background of the problem, the problem statement, the purpose of the study, and the specific research questions I sought to answer. In addition to giving an overview of the study’s conceptual framework and methodology, I define key terms and discuss the assumptions, scope, limitations, and delimitations of my research. This chapter also includes a brief discussion of the significance of the study. It ends with a brief summary of the chapter and a preview of Chapter 2.

Background of the Problem

Projections of the older adult population in the Philippines estimated an increase in the number of adults 65 and older (Varona et al., 2007). In their caregiving and caregiver study, Varona et al. (2007) noted that the number of older adults is increasing, which is indicative of increased life expectancy. This increased life expectancy is associated with a concurrent increased prevalence of chronic disease along with an increased dependency on caregivers and caregiving services (Varona et al., 2007). As the Commonwealth Fund (2005) and the National Alliance for Caregiving (2009) have noted in the United States, the need for, and the number of, caregivers has increased because of the increase in the number of older adults. Caregivers can be either unpaid family members or relatives or paid professionals (National Alliance for Caregiving, 2009). Several factors influence the commitment to provide caregiving services for family members; these include residing with or near the care recipient (Varona et al., 2007) and cultural values (Nadal, 2011).

Unpaid family caregivers face challenges specific to their role as caregivers. These include physical, psychological, emotional, social, and financial stressors which increase caregiver burden (Varona et al., 2007). In the United States, Filipino American family caregivers often underuse available caregiving services such as home health care, respite services, and case management, which may complement the services they provide (Kimura & Brown, 2009). They underuse these services due to lack of availability or awareness of available services (Kimura & Brown, 2009). Service utilization by Filipino American caregivers has also been hampered by factors including socioeconomic status, immigration status, benefit and service restrictions for immigrants, cultural issues, and experiences with discrimination (Kimura & Brown, 2009). Researchers have not addressed the difficulties or challenges, rewards, and other sociocultural factors that affect Filipino American caregivers.

I undertook this study in order to fill the gap in knowledge regarding the difficulties and rewards associated with the Filipino American caregiving experience. I acknowledged the central role that family and friends play in providing care for ailing family members (Kataoka-Yahiro, 2010) through an examination of research participants' lived experiences. In doing so, I was able to identify and describe how sociocultural factors such as cultural values and life roles influence the rewards, difficulties, and challenges experienced by Filipino American caregivers. Identifying these unique aspects of the Filipino American caregiver experience may enable researchers and social workers to more accurately assess and meet the needs of these individuals. By bridging this gap in the literature, researchers, social workers, and policy makers may be able to develop effective support sources, intervention models or procedures, and relevant health care policies that are culturally sensitive and relevant to Filipino American caregivers (Kataoka-Yahiro, 2010).

Problem Statement

An estimated 65.7 million Americans provided some form of caregiving activity for ill or debilitated family members or relatives in 2009 (National Alliance for Caregiving, 2009). For the National Alliance of Caregiving's (2009) study, *family member* referred to the immediate family of the participant (e.g., husband, wife, mother, father, daughter, son, brother, sister, grandparent, and grandchild). Any participant who was not a member of the immediate family of a care recipient (e.g., mothers- or fathers-in-law, other in-laws, aunts, uncles, and cousins) was referred to as a *relative*.

Authors of the National Alliance of Caregiving (2009) study estimated that 20% (or, 0.9 million) American caregivers were Asian Americans. They did not include more specific information about Asian American subgroups that were represented in their study. Filipino Americans' status as an invisible minority may account for this lack of attention. Researchers and demographers have underrepresented and understudied Filipino Americans in various studies of Asian Americans (Kimura & Brown, 2009). Additionally, Filipino Americans have frequently been classified as *Asian Americans* or *Pacific Islanders* (Nadal, 2011). The terms *race* and *ethnicity* have commonly been used interchangeably to indicate people of the same nationality (APA, 2007). However, APA (2007) has clarified that although race and ethnicity are both social concepts, race refers more to individuals who share the same physical characteristics, geographic location, and nationality. Ethnicity refers to an individual who is a member of, or who identifies with a particular ethnic group, based on similarities in history, culture, language, and sometimes, religion (APA, 2007). For this study, references to Filipino American cultural values will indicate identification with Filipino American ethnicity (APA, 2007).

Despite an increased number of studies of caregiving, there is a gap in the literature with regards to specific details of the nature of caregiving (e.g., difficulties, successes, satisfactions, and inspirations associated with undertaking this demanding role; Barbosa, Figueiredo, Sousa, & Demain, 2011). Based on my review of the literature, researchers had not examined the influence of Filipino cultural values and other sociocultural factors such as immigration status and its processes of enculturation, acculturation, and assimilation on the experience of Filipino American caregivers. My purpose in undertaking this study was to understand and describe how Filipino cultural values and life roles may affect Filipino American caregivers.

By collecting and analyzing interview data on Filipino American caregivers’ lived experiences, I was able to identify and document some of the unique difficulties and rewards associated with being a Filipino American caregiver. Based on the findings of this study, researchers, social workers, and policy makers may be able to address some of the needs of Filipino American caregivers. This may lead to the provision of effective, culturally sensitive, and relevant support sources, intervention models or procedures, and health care policies that can benefit Filipino American caregivers (Epiphaniou et al., 2012).

Purpose of the Study

The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino American experiences of the caregiver role. I used a phenomenological research design (Moustakas, 1994) in order to understand how Filipino American caregivers related to and understood their experience of caregiving, as well as the meaning they attach to their caregiving experience.

Research Questions

Main RQ: What is the lived experience of Filipino American caregivers?

Secondary RQ 1: How do Filipino American caregivers describe the personal impact of caregiving for their family members?

Secondary RQ 2: How do sociocultural factors impact the role of the Filipino American caregiver?

Conceptual Framework

The conceptual framework on which this study was based included the sociocultural stress and coping model (SSCM; Knight & Sayegh, 2010). Knight and Sayegh (2010) developed the Sociocultural stress and coping model as a means to explain how caregivers from different ethnic backgrounds are affected by the caregiving role, specifically through the influence of cultural values, social support, and coping style (Knight & Sayegh, 2010). One purpose of this study was to examine the impact of sociocultural factors such as Filipino cultural values, on the caregiver role of the Filipino American. Additionally, every culture is unique and influenced differently by the dominant culture in any foreign land. Given that most Filipino Americans immigrated to the United States from the Philippines, Filipino cultural values provided a basis for which the impact of the caregiver role on the Filipino American was considered (Nadal, 2011). McCallum, Longmire, and Knight (2007) noted in their updated SSCM, ethnicity was seen as a disadvantaged status that was complicated by socioeconomic factors (McCallum, Longmire, & Knight, 2007). Specifically, ethnic differences in caregiving outcomes were some factors that were associated with the disadvantaged status associated with ethnicity. Some of the socioeconomic factors that complicated this status included the perception of burden associated with caregiving, caregiver income, health outcomes of both the caregiver and care recipient, and lastly, cultural beliefs about the care of elderly family members (McCallum, Longmire, & Knight, 2007). The purpose of this study was to determine whether the Filipino American perception of the caregiving role was affected or influenced by Filipino cultural values and life roles.

Nature of the Study

I conducted this study using a qualitative research method, specifically, phenomenology. Moustakas (1994) developed phenomenology as a research process to understand the lived experiences of participants. The use of phenomenology enabled participants in my study to convey an in-depth understanding of the events and meaning in their lives, as they were shaped by their cultural settings (Moustakas, 1994). Although the phenomenon of caregiving is more prevalent (Varona et al., 2007), researchers have not adequately explored this phenomenon from the Filipino American perspective, based on my review of the literature. I sought to address this gap in the literature through my investigation. Conducting in-depth interviews with study participants allowed me to discover and examine themes related to Filipino Americans' experience of caregiving. In doing so, I added to the literature regarding Filipino Americans.

I sought participants for this study, including male and female Filipino Americans who lived in the Southwest region of Houston, Texas, who had been in the caregiver role for at least a year and who were either a first or second generation Filipino American. I assumed that the longer an individual had been in the caregiving role, the more varied their experiences. Also, I assumed that a year was an adequate amount of time for the caregiver and care receiver to have established a care routine that was a baseline for the caregiver to describe their experiences. This area was chosen as a location where I conducted in person interviews as well as increased my accessibility to potential participants. Participants must have cared for either a spouse or a relative with a chronic illness or disability which required constant supervision and participation in caregiving activities as described in the definitions section, and they must not have received payment for the care they provided their family member or relative. This allowed for the examination of the potential influence of Filipino cultural values on the individual. Moustakas’s (1994) steps in data analysis were used to reveal common themes and/or categories that were discovered either through face-to-face or telephone interviews. A more detailed explanation of the methodology, including specific interview questions and data analysis procedures was presented and discussed in Chapter 3.

Definitions

Acculturation: A “process in which members of one cultural group adopted the beliefs, values, and behaviors of another (cultural) group” (Nadal, 2011, p. 297).

Assimilation: A “process in which members of one cultural group abandoned their own (cultural) beliefs, values, and behaviors and fully adopted those of another or new host group” (Nadal, 2011, p. 297).

Caregiver: Any unpaid individual who cared for a relative or family member most hours of the day, most days of the week (National Alliance of Caregiving, 2009). This description of a caregiver was updated to specify, a higher hour caregiver as one who provided at least 21 hours of care per week and a lower hour caregiver as one who provided 20 hours or less per week (National Alliance of Caregiving, 2015). For the purpose of this study, caregivers must have provided at least 10 hours per week of care for a relative or family member.

Caregiving activities: Activities of daily living, instrumental activities of daily living, and other activities including but not limited to advocating for the care recipient, administering medical therapy or medical treatment, and enforcing special diets for the care recipient (National Alliance of Caregiving, 2009).

Care recipient: Any individual who received care from an unpaid relative or family member most hours of the day, most days of the week (National Alliance of Caregiving, 2009).

Emic: An “insider’s perspective” (Hamill & Sinclair, 2010, p. 17).

Enculturation: A “process whereby an individual learned the accepted norms and values of an established culture” (Nadal, 2011, p. 299).

Ethnicity: A “social categorization based on an individual’s membership in or identification with a particular ethnic group” (American Psychological Association [APA], 2007, p. 345).

Ethnic group: “a major social group that possessed a common ethnic identity based on history, culture, language, and often, religion…an ethnic group was not equivalent to a race” (APA, 2007, p. 345).

Etic: An “outsider’s perspective” (Hamill & Sinclair, 2010, p. 17).

Filipino cultural values: “four main values; namely, *kapwa* (fellow being), *utang na loob* (debt of reciprocity), *hiya* (shame), and *pakikisama* (social acceptance)” (Nadal, 2011, p. 38).

Race: “a socially defined concept…used to designate a portion of the human population with common physical characteristics, ancestry, or language” (APA, 2007, p. 765).

Sociocultural factors: colonization; immigration and the processes of acculturation, assimilation, and enculturation; and Filipino cultural values (Nadal, 2011).

Assumptions

Despite a cultural value of privacy, I assumed that Filipino American caregivers were willing to become study participants. I also assumed that Filipino American caregivers were willing to talk openly about their experiences as a caregiver once this researcher ensured the participants understood the following: what this study was about, the participants’ and the researcher’s roles, as well as the concepts of informed consent and privacy. I also assumed that participants spoke truthfully and candidly about their experiences as it related to this study (Varona et al., 2007).

Scope and Delimitations

This study focused on Filipino American caregivers as participants. For purposes of this study, a caregiver was defined as any Filipino American male or female, who was at least 21 years of age, unpaid, and had been caring for their relative or family member for a minimum of a year. The care recipient in this study was defined as any Filipino American male or female, of any age and gender, with a debilitating or chronic illness that required constant care, who was still living and was not institutionalized. The care recipient was not considered a participant in this study. Participants whose care recipient passed away recently may be considered for inclusion in the study only if the care recipient passed away within 18 to 24 months of their caregiver's scheduled interview. Although the results of qualitative research were not meant to be generalizable or transferable, the results of this study were applicable to Filipino American caregivers in general, but were not generalizable to other individuals of other Asian American ethnicities. The results of this study also led to the generation of hypotheses regarding Filipino American caregivers and how they were affected by their role.

Limitations

This study was limited to participation of Filipino American families and their caregivers. Other caregivers of different ethnicities were not considered for this study. Limiting this study to these participants was necessary in the sense that it is not the purpose of phenomenological studies to have generalizable or transferable results. This limitation of phenomenological studies was discussed further in Chapter 3, in Issues of Trustworthiness. Another limitation to the study was that participants were initially identified through the Catholic Church pastoral groups, outreach ministry groups, and Filipino community groups that involve caregivers. Another limitation of this study included the potential for interviewer bias. This was a concern, since while interviewing participants for this proposed study, there was a possibility that interview questions were leading, too subjective, or even culturally inappropriate. This potential issue was addressed by presenting a draft of the interview questions to the dissertation chair as well as the Walden University Institutional Review Board (IRB) to ensure the appropriateness of the interview questions as well as the overall methodology. Another potential source of bias was responder bias, where a study participant may have answered interview questions with answers they thought the researcher expected or even preferred. Additionally, the Filipino cultural value of privacy was also a potential source of problems related to responder bias. In this case, there was the potential for the responder to be reluctant to answer. Some of the measures proposed to deal with responder bias included ensuring the potential participant understood the purpose of the study, and their role as well as the researcher's role in the study. Additionally, I made sure the potential participant understood the concept of informed consent and I reassured the participant that their privacy was respected during the study, along with ways to prevent responder bias.

Significance

This study was unique in that it provided a new perspective on the caregiving experience, specifically that of Filipino Americans. Filipino Americans were considered to be an underrepresented, understudied, and underreported subgroup of Asian Americans (Kimura & Brown, 2009). Helping professionals would do well to be aware of the influence of Filipino cultural values and processes such as enculturation, acculturation, and assimilation on the Filipino American caregiver's role (Nadal, 2011, p. 77). Additionally, mental health professionals must be aware of the influence racial and/or ethnic identity had on individual's worldviews, interpersonal relationships, and coping skills (Nadal, 2011, p. 78).

The results of this study had implications for positive social change. For instance, the study can lead to the identification of effective support sources through an increased awareness of the unique difficulties and rewards associated with the Filipino American caregiving role (Epiphaniou et al., 2012). Additionally, this study may have offered results that can lead to a more accurate assessment of the needs of the Filipino American caregiver, which could result in the development of interventions and health policies that are both culturally sensitive and culturally relevant to the Filipino American caregiver (Epiphaniou et al., 2012).

Summary

Improvements in health care for the elderly have resulted in longer lifespans as well as increased incidence and prevalence of chronic diseases (Varona et al., 2007). The need for caregivers for the elderly as an alternative to institutionalized care had also increased (Varona et al., 2007). Of the estimated 0.9 million Asian American caregivers, it was not known which subgoups were included. As such, information specific to Filipino American caregivers was limited (National Alliance for Caregiving, 2009).

The goal of this study was to explore the experience of caregiving regarding its effect on Filipino American caregivers, as told through their lived experiences. Specifically, factors that may have influenced Filipino American caregiver's commitment to caring for an ailing family member were examined; including, Filipino cultural values such as close family ties and respect for one's elders (Varona et al., 2007) and life roles. Other problems related to caregiving were also examined, including associated psychological, emotional, social, and financial stressors (Varona et al., 2007). Further, this study filled a gap in literature regarding the difficulties, successes, satisfactions, and inspirations associated with the caregiving role (Barbosa et al., 2011). The sociocultural stress and coping model (Knight & Sayegh, 2010) provided the conceptual framework for this proposed study. The phenomenological research method was used in this study to examine and answer the main research question, “What is the lived experience of Filipino American caregivers?”

Positive social change can be effected through this study with the knowledge gathered regarding the influence of Filipino cultural values on the Filipino American caregiver’s role (Nadal, 2011). It can be possible to identify effective support sources for Filipino American caregivers (Epiphaniou et al., 2012). Nadal (2011) suggested that future studies should explore: (a) the influence of Filipino American cultural values and life roles on individuals’ worldview, (b) interpersonal relationships, (c) coping skills as well as (d) the unique difficulties and rewards associated with the Filipino American caregiving role. In developing a more accurate assessment of the needs of Filipino American caregivers, it can be possible to create interventions and health policies that were both culturally sensitive and culturally relevant for members of this group (Epiphaniou et al., 2012). In this way, care recipients can enjoy improved quality of life as a result of high-quality care provided by healthy caregivers (Varona et al., 2007). Additionally, results of this study can also lead to the generation of hypotheses regarding Filipino American caregivers and how they were affected by their role.

Chapter 2 begins with the literature search strategy. The conceptual framework follows, which includes a discussion of the sociocultural stress and coping model, the caregiver empowerment model and the COPE model. This is followed by the literature review. In the first part of the literature review, I discussed the present situation of caregiving, as well as present-day recognition of the need and importance of caregiving and caregivers. The last portion of the review of literature included a discussion of caregiving as a role that certain individuals undertook, as it was influenced by such factors as Filipino cultural values, and life roles. I concluded Chapter 2 with a summary.

Chapter 2: Literature Review

Introduction

Despite an increased number of studies related to caregivers and caregiving, a gap existed regarding specific studies on Filipino American caregivers. Although the number of Asian American caregivers was estimated at 0.9 million (National Alliance for Caregiving, 2009), specific demographic information regarding the Asian American subgroups within this number is not known. Nadal (2011) observed that researchers consistently underrepresented Filipino Americans in studies that involved Asian Americans. One reason for the underrepresentation of Filipino Americans is the common classification of Filipino Americans as either Asian American or Pacific Islander, which illustrates the confusion regarding what ethnic group Filipino Americans represent (Nadal, 2011). The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino American experiences of the caregiver role.

Results of my study may result in positive social change by increasing awareness of the unique difficulties and rewards associated with the Filipino American caregiving role, as gleaned from analysis of in-depth interviews. Additionally, the results of this study may also assist researchers, social workers, and policy makers in the development of a more accurate identification of effective support sources for Filipino American caregivers. In turn, the identification of effective support sources may contribute to a more accurate assessment of the needs of Filipino American caregivers (see Epiphaniou et al., 2012). This increased awareness may benefit Filipino American caregivers and their families if the results of this study are used to support the development of future interventions and health policies that are culturally sensitive and also culturally relevant to Filipino American caregivers (Epiphaniou et al., 2012).

In the first section of this chapter, I present an overview of the literature search strategy I used. This is followed by a discussion of the conceptual framework, which includes descriptions of the sociocultural stress and coping, the caregiver empowerment, and COPE models. The literature review follows. The first part of the literature review includes an overview of research on current aspects of caregiving and recognition of the need for and importance of caregiving and caregivers. This is followed by a section on caregiving as a role that certain individuals undertake. Included in this section is a consideration of what factors influence the caregiving role.

Literature Search Strategy

As I began to search for literature for this study, I used the multidatabase search engine Thoreau within the Walden University Library website. I used broad, general search terms or key words, specifically, *caregiver*, *caregiving*, and *phenomenology*. Using these three key words yielded 346 articles with the terms *caregiver* and *caregiving* in the title. Most of these articles were related to nursing and end-of-life care issues involving professional caregiving staff. For purposes of narrowing down the literature search, I disregarded articles that involved professional caregiving staff (e.g., professional medical providers such as physicians and nurses) in favor of articles that focused on family-based informal caregiving. Examination of the ethnicity of the participants in each article indicated that a majority of the articles focused on Latinos, individuals of Middle Eastern descent, or Asians other than Filipinos. For narrowing down the scope of this study, I collected and saved articles that had Latino or European Spanish participants because I considered these articles to be relevant in light of the Filipino people's history of colonization under Spanish rule (Nadal, 2011). Additionally, search results using the keywords *caregiver*, *caregiving*, and *phenomenology* yielded 35 articles which had as participants adult patients with widely varied illnesses such as dementia, cancer, and schizophrenia as well as children with chronic illnesses.

Searching SocIndex with these key words yielded 32 articles that were originally in my results list from my search of CINAHL Plus. Similarly, searching Academic OneFile, InfoTrac Health Reference Center Academic, and ScienceDirect databases yielded the same articles. In order to manage the number of articles included in the literature review, I limited care receivers or care recipients with chronic diseases to those who had either a neurodegenerative disease (e.g., Alzheimer's or Parkinson's disease) or debilitating symptoms such as being wheelchair bound or bed bound. When I inserted the key word *phenomenology* in the search field, along with *caregiver* and *caregiving*, no matching articles were found.

A new search within Thoreau, using the key words *Filipino* and *caregiver*, resulted in 119 articles. However, a majority of these articles focused on Filipino migrant workers, specifically nurses, who are considered to be professional caregivers. Thus, I discarded a majority of these articles in order to maintain the consistency of the inclusion criteria for articles. In all, I found 18 articles I considered relevant to this dissertation.

I conducted this comprehensive literature search using nine online databases: Academic Search Complete, Education Research Complete, Educational Resources

Information Center, ProQuest Central, ProQuest Dissertations and Theses Database, PsycARTICLES, PsycINFO, Science Direct, and SocIndex. Aside from the Walden University Library website, I used the SAGE Research Methods database to search articles relevant to phenomenology and phenomenology in the context of caregiving. The following additional search terms were used: *Asian American caregiver*, *caregiver anxiety*, *caregiver burden*, *caregiver depression*, *Filipino American caregiver*, and *Latino American caregiver*. I limited the literature search to scholarly, peer-reviewed articles, and dissertations published from 2008-2014. I also saved older studies published from 2000-2007 to understand the development or progression of studies on caregiving and Filipino American caregivers to the present time. I also considered visiting government agency websites such as the Centers for Disease Control (CDC), the National Institute of Mental Health (NIMH), and National Institutes of Health (NIH) for the most current data on caregiving and caregiving practices.

Conceptual Framework

It was estimated in 2009 that approximately 65.7 million Americans acted as caregivers for ill or debilitated family members or relatives (National Alliance for Caregiving, 2009). A *caregiver* was described as an unpaid family member who provided care most hours of the day, most days of the week (National Alliance for Caregiving, 2009). Specific demographic information such as how many of these were Filipino Americans or Asian Americans was not specified by the National Alliance for Caregiving (2009).

Nadal (2011) described the current situation of Filipino American caregivers as uniquely influenced by several factors. Most first-generation Filipino Americans emigrated to the United States from the Philippines. As such, Filipino American life experiences have been shaped by Filipino culture and cultural values, traditions, and beliefs (Nadal, 2011). I had a goal to describe how being Filipino American may have influenced the caregiver role through this study. I wanted to describe how cultural values and life roles influenced Filipino Americans' perceptions of being a caregiver. I evaluated cultural values such as respect for elders, filial piety, and collectivism in terms of their influences on Filipino American caregivers' lived experiences, with an emphasis on the effects of these experiences on the stress and coping process (Nadal, 2011).

The Sociocultural Stress and Coping Model

Aranda and Knight (1997) detailed the sociocultural stress and coping model (SSCM) as a way to reframe the perception that ethnicity was indicative of a disadvantaged position in society that was complicated by socioeconomic factors. McCallum, Longmire, and Knight (2007) updated the original SSCM in order to reinterpret the impact of ethnicity on stress and methods of coping. McCallum et al. (2007) noted that ethnicity influenced, (a) characteristics of caregivers, (b) demands of the caregiving role, (c) appraisal of caregiving as a stressful activity, through cultural values, (d) coping styles as further influenced by cultural differences, and (e) positive and/or negative health outcomes of the stress and coping process.

In yet another revision of the original SSCM, Knight and Sayegh (2010) put forth the hypothesis that East Asian cultural values had a protective effect that countered the appraisal of caregiving as burdensome. This was because East Asian cultural values emphasized respect and care for elders, filial piety, mutual support, and collectivism (Nadal, 2011). In comparison with the previous versions of the SSCM, the latest version had the same limitations, such as the inability to generalize the model to various ethnicities of caregivers. Knight and Sayegh (2010) stated in the latest version of the SSCM that culture could have affected the stress and coping process. As such, care must be taken to examine the cultural and ethnic differences in caregiving, and not simply ascribe these differences to ethnicity or ethnic group membership. Another limitation among all the versions of the SSCM was the dependence on self-report measures to assess general caregiver health. Greater validity in assessing caregiver health can be achieved by incorporating physiological measures of health in addition to subjective self-report measures.

McCallum et al. (2007) originally developed the SSCM to examine the influence of ethnicity on caregiver characteristics, caregiving demands, appraisal of caregiving as either a challenge or a burden, as well as the influence of cultural values on coping styles and, positive and/or negative outcomes of the stress and coping process in the context of the caregiving experience. McCallum et al. (2007) provided currently held perceptions of the caregiving role, focusing on the variables of ethnicity, caregiver characteristics, appraisal of caregiving, as well as the positive and negative effects of caregiving through the SSCM. The view that cultural values such as familism and filial piety influenced coping style as well as coping resources such as social support was supported by research (Knight & Sayegh, 2010). Cultural values also had an indirect effect on caregiver outcome through its effect on caregiver burden appraisal, coping methods, and perceptions on social support (Knight & Sayegh, 2010). This model therefore was a good fit with regards to providing insights into potential influences on the lived experiences of Filipino American caregivers, with a focus on social and cultural factors, as detailed in the following literature review.

Empowering Caregivers

The caregiver empowerment model (CEM). Jones, Winslow, Lee, Burns, and Zhang (2011) developed the caregiver empowerment model (CEM) as an additional resource for caregivers in order to elicit positive outcomes from the caregiver experience. Much had been studied in relation to the negative effects of the caregiving experience, but little was known about the positive effects of the caregiving experience. If understanding of the total caregiving experience was needed, as Jones et al. (2011) suggested, positive caregiving outcomes can also be studied.

The CEM was based on the health empowerment model (Jones & Meleis, 1993) as well as the theory of meaning-focused coping (Folkman & Mosokvitz, 2000). The health empowerment model indicated that personal, family, and community resources all worked to empower the caregiver by providing additional resources the caregiver can call on to manage a problematic caregiving situation effectively and appropriately, thus increasing the potential for positive outcomes. Additionally, when caregivers saw these problems as a challenge rather than a burden, having additional resources can embolden them to do more to advocate for their care receivers’ health (Jones et al., 2011). In Folkman and Mosokvitz’ (2000) theory of meaning-focused coping, finding meaning in any situation motivated individuals to not simply endure, but rather to rise to the challenge that particular situation brings (Jones et al., 2011).

Empirical foundations of the CEM focused on background variables and filial or family values. Background variables such as acculturation, demographic variables, and the nature of the caregiver’s prior relationships were all thought to have influenced the development of the CEM (Jones et al., 2011). Acculturation was thought to influence filial responsibility, coping strategies, and resources in caregiving. Demographic variables such as race and ethnicity were associated with influencing the resources available to the caregiver, while gender was thought to have influenced filial values. The nature of the caregiver’s prior relationships was thought to have influenced the quality of the interaction the caregiver had with the care receiver, as well as the quality of care that was given to the care receiver (Jones et al., 2011).

Filial values on the other hand, were thought to have influenced a caregiver’s motivation in caring for elderly parents or relations (Jones et al., 2011). It was indicated in the CEM that filial values may have influenced how individuals saw caregiving as either a challenge or a burden. Filial values may have also increased the resources available to caregivers through the meaning and sense of purpose caregivers found in caring for their elderly parents (Jones et al., 2011).

The COPE model. The COPE model was initially designed by Houts et al. in 1996 as a teachable problem-solving skill. The components of COPE included creativity, optimism, planning, and expert information (Bahrami & Farzi, 2014). In caring for any individual with a chronic disease such as cancer, prolonged time in the caregiving role had detrimental outcomes, such as emotional effects (depression, anxiety), social effects (isolation), physical effects (fatigue), professional effects (absenteeism, unemployment), and economic effects (financial problems brought about by rising medical fees). In time, these effects caused the quality of life of the caregiver to decrease or become impaired. It was useful to note that a caregiver's quality of life was directly influenced by the perceived burden of caring (Bahrami & Farzi, 2014). If the caregiver's quality of life is improved, it follows that the perceived burden is decreased.

In Bahrami and Farzi's (2014) study, the COPE model was applied to the educational support Iranian caregivers (who took care of women with breast cancer) received. For the *creativity* component, participants were encouraged to think of additional ways to solve a particular problem they were having, related to providing care (Bahrami & Farzi, 2014). Regarding the *optimism* component, participants were encouraged to think positively, albeit realistically (Bahrami & Farzi, 2014). For the *planning* component, participants were encouraged to set goals and ways in which to achieve them (Bahrami & Farzi, 2014). Last, for the *expert information* component, study participants were encouraged to learn useful problem solving skills from experts in their industry (Bahrami & Farzi, 2014).

Jones et al. (2011) developed the CEM as an additional resource apart from simple coping mechanisms to empower caregivers by detailing the influence of acculturation, demographic variables, and prior relationships on the outcomes of the caregiving experience. Jones et al. (2011) concluded that filial values influenced caregivers' meaning and sense of purpose when it came to finding fulfillment in caring for their aging parents. Bahrami and Farzi (2014) developed the COPE model as an easy, practical application of coping methods to yield positive caregiving results. By knowing the effects of social and cultural factors on the caregivers' perception of what was stressful in their lived experiences, measures can be developed and supported based on the CEM and COPE models to help caregivers experience more positive outcomes.

Literature Review

Cultural Factors Affecting the Caregiver Role

Filipino History of Colonialism. The Filipino people had a unique history of colonialism by and immigration to the United States. The Philippines was the only Asian country to be colonized by Spain for almost 400 years as well as directly occupied by the United States for almost 50 years (David & Nadal, 2013). Because of these periods of colonization, Philippine culture was strongly influenced by the Spanish and American cultures. Lasting Spanish influences included Spanish surnames, Roman Catholicism, and Spanish words that were incorporated into the Filipino language (Nadal, 2011). The American influence on Filipinos and Philippine culture was also strong as evidenced by the Philippines being one of the only Asian countries to have English as a second national language, adopting the American curricula in education, as well as being exposed to American trends and culture through American television shows (Nadal, 2011). Because of these periods of colonialization and occupation by foreign countries, it was not only inevitable that Filipino culture would be influenced by other cultures, but also possible that indigenous cultural values would be ignored or even forgotten (Nadal, 2011). Compared to Filipinos who remained in the Philippines, Filipino Americans had different experiences, for a number of reasons; for instance, Filipino Americans were considered to be a minority, Filipino Americans were more likely to encounter individuals from other racial or ethnic groups, and Filipino Americans may have experienced discrimination and racism that were absent in their country of origin (Nadal, 2011).

Filipino Cultural Values. Prior to colonialization, Filipino cultural values were largely indigenous. In general, pre-colonialization Filipino values were described as collectivistic and gender-neutral, with males and females treated and respected equally and afforded the same opportunities. Nadal (2011) observed that compared to Filipino Americans, Filipinos who stayed in the Philippines were more likely to be self-assured about their culture and ethnic identity. This may be because Filipinos outside the Philippines tended to compare themselves and their general situation less favorably to the majority culture (Nadal, 2011).

In Filipino culture, there were two particularly deep-seated cultural values; close family ties and having the utmost respect for one’s elders. Close family ties ensured that family needs were placed first before any individual needs and that major decisions cannot be made without consulting family members (Nadal, 2011). In line with having close family ties, the elderly members of the family were considered to have much knowledge and insight with regards to life experiences. Therefore, major decisions were made only after consulting with the elderly members of the family. As a sign of gratitude, elders were encouraged to stay indefinitely with their adult children. This was not seen as a burden by the children (Nadal, 2011). Rather, it was an honor to take care of one’s parents in their old age.

According to Nadal (2011), there were four fundamental Filipino values: *kapwa* (fellow being), *utang na loob* (a debt or norm of reciprocity), *hiya* (shame or loss of propriety), and *pakikisama* (social acceptance or conformity). *Kapwa* was a core construct of Filipino psychology. In this cultural value, there was a sense of togetherness or connectedness to one another, which in some ways was similar to the American value of collectivism, where interdependence and a sense of community were stressed (Nadal, 2011). *Utang na loob* was a Filipino value whereby favors were expected to be returned or exchanged, whether or not these favors were asked for or needed. *Hiya* was a Filipino cultural value whereby individuals were expected to represent themselves or their family in the best way possible in order to avoid shame or embarrassment, to act responsibly, and to be successful and make their family proud (Nadal, 2011).

Nadal (2011) also described secondary Filipino values. Secondary Filipino values included *close family ties* and *utmost respect for elders*. For Filipinos, close family ties included the expectation that one will put the collective good before individual needs. Furthermore, Filipinos considered the “immediate family” to have included grandparents, aunts, uncles, and cousins in addition to parents and siblings. Family decision-making activities were a major affair, with multiple family members who provided input before a final decision was made. As mentioned earlier, elderly family members were considered to have much life experiences and therefore, their advice was considered highly valuable (Nadal, 2011).

There were several factors that uniquely influenced the Filipino caregiving experience. Foremost among these was the priority Filipinos placed on familial relationships. In Filipino culture, birth order did not dictate who bore the caregiving responsibility. Instead, for purposes of practicality, those family members who were co-residents with the care recipient or who lived in close proximity assumed caregiving responsibilities (Varona et al., 2006).

Filipino cultural values such as deference to the elderly and *utang na loob* or debt of gratitude also determined how devoted an adult child was when it comes to caring for elderly parents (Varona et al., 2006). Another factor that may have influenced the Filipino caregiving experience was the financial hardship associated with caregiving. For those living in the Philippines, these difficulties were exacerbated because social welfare systems and insurance systems were disorganized and sometimes informal. Government programs for the poor and the elderly were few and, if existing, quite limited in their offerings for the elderly and the destitute. Private medical and surgical services in the Philippines were simply too expensive for the elderly and their families (Varona et al., 2006). Unlike in the U.S., where having medical or health insurance was mandatory, Filipinos did not have a health insurance system in place that assured coverage to every individual who needed it.

Losada et al. (2010) considered familism to be a positive influence that ameliorated caregiver distress only if and when the family was perceived to be supportive. Familism was defined as “a strong identification and attachment of individuals and their families (nuclear and extended), and strong feelings of loyalty, reciprocity, and solidarity among members of the same family” (Losada et al., 2010, p. 194). Familism was thought to have influenced feelings of obligation to provide care in addition to attitudes and behaviors that were thought to be followed by different family members. Familism was related to a major secondary Filipino value, which was having close family ties (Nadal, 2011). In an effort to examine the influence of familism on dementia caregivers in Spain, Losada et al. (2010) conducted a study that used some factors on the familism scale (specifically, Familial Obligations and Family as Referents factors). Losada et al. (2010) tried to determine if there were associations between these two factors and dysfunctional thoughts about caregiving and if there were associations, whether the overall effect was detrimental to the perception of caregiving. The results of Losada et al. (2010) suggested that familism affected emotional distress through dysfunctional thoughts rather than burden appraisals. Although familism was a factor that influenced the caregiver to provide care out of obligation, caregiver distress in the face of familism was apparent when dysfunctional thoughts about caregiving were present, instead of when caregiving was perceived as a burden.

Social Factors Affecting the caregiver role

Gender. The Philippines had a long history of being colonized by Spain. In fact, Spain had colonized the Philippines for a period spanning 300 years. As a result of this, Spanish culture had a major influence on Philippine culture. In a study conducted by del Pino-Casado, Frias-Osuna, Palomino-Moral, and Martinez-Riera (2012) in Spain, gender differences among family caregivers of older disabled individuals were examined. Specifically, del Pino-Casado et al. (2012) examined whether gender differences existed in the intensity of care provided (determined through the amount and type of care given), the time spent providing care, subjective burden, and the satisfaction the caregiver felt.

Spanish culture was characterized by strong beliefs regarding the role women played in caregiving (i.e. caregiving was traditionally regarded as a woman's role). This cultural belief was similar to or related to Filipino cultural values of *utang na loob* or debt of gratitude, as well as having the utmost respect and deference to one's elders.

Results of the del Pino-Casado et al. (2012) study led to the conclusions that no gender differences existed with regard to the intensity of care provided, the time spent caregiving, or the satisfaction caregivers felt while providing care. The authors concluded, however, that there were gender differences when it came to subjective burden reported by family caregivers. Furthermore, this gender difference was culturally influenced by the Mediterranean model of informal care which had the following characteristics: positive attitudes regarding caring for older relations, family involvement or participation in the care of older relatives; a pervasive belief that it is the role of the woman to provide care; the majority of female caregivers being unemployed; and, lower levels of formal caregiving (del Pino-Casado et al., 2012).

The Mediterranean model of informal care, as noted above, supported the belief that women were responsible for providing care in the family; this lead to a greater proportion of women caregivers (del Pino-Casado et al., 2012). This fact must be considered as potentially affecting the perception that women were "more involved" in caregiving compared to men; and, those conducting studies on gender differences in caregiving must take this into consideration. With Filipino American caregivers, the Mediterranean model of informal care can be applied to examining gender differences among caregivers because of the long history of Spanish colonization in the Philippines.

del Pino-Casado et al. (2012) further noted that caregiving was a stressful undertaking and thus can negatively impact caregiver health. When women participated in caregiving activities and eventually become primary or sole caregivers, they put themselves at risk of negative consequences ranging from the physical to the psychological (del Pino-Casado et al., 2012).

Full-time employment, multiple caregiver roles: Reconciling work-family roles. As was mentioned in the short introduction to the Review of Literature, the following study was conducted with the help of a sample population that was randomly chosen from survey results. Thus, the results presented here were meant to help draw analogies which may apply to Filipino American caregivers. Bainbridge, Cregan, and Kulik (2006) conducted a study in order to examine whether being employed outside of (family) caregiving would have had an impact on the stress outcomes of caregivers who had a care recipient with disabilities. As Bainbridge et al. (2006) used a sample that was randomly chosen from surveys, their results applied to Filipino American caregivers. They concluded that simply being employed outside of caregiving had neither a beneficial nor an adverse effect on caregiver stress outcomes (Bainbridge et al., 2006). What impacted stress outcomes more than being employed was the type of disability the care recipient had, aside from the number of hours the caregiver worked each week in addition to caregiving (Bainbridge et al., 2006). To clarify, if the care recipient had a non mental disability, the number of hours the caregiver spent at work (outside the home) had no effect on the caregiver's stress outcome. However, if the care recipient had a mental disability, hours the caregiver spent at regular employment proved to be beneficial for the caregiver (Bainbridge et al., 2006).

In a more recent study that examined reconciling work and family caregiving, Wang et al. (2010) examined the effects of full-time or part-time work status, inflexibility of work roles, and difficulties balancing employment and family responsibilities on family caregivers. Specifically, Wang et al. (2010) wanted to determine the effects of having an added role of being a family caregiver on the possibility of developing depression and reporting difficulty balancing work and caregiving responsibilities. Full-time employment and difficulty reconciling work demands and caregiving responsibilities predicted role strain, in addition to work inflexibility predicting depressive symptoms in caregivers (Wang et al., 2010).

The interaction among caregiver stress, family-work conflict, and burnout was further examined by McDaniel and Allen (2012). The results of their study indicated that traumatic caregiver stress was directly related to family-work conflict, psychological strain, and burnout (McDaniel & Allen, 2012). A family caregiver was often seen as either the primary or even the only caregiver in the family. Such caregivers were also considered informal caregivers and therefore were often unpaid. Because of these perceptions, family caregivers were in danger of losing or even quitting their regular jobs because of lateness, absenteeism, job dissatisfaction, poor job performance, and turnover (McDaniel & Allen, 2012). Furthermore, family caregivers were more at risk of suffering from mental health problems such as psychological strain, burnout, depression, and anxiety (McDaniel & Allen, 2012).

Filipino immigration to the United States. Filipinos arrived in the United States in three major waves. The first wave of Filipino immigrants to the United States arrived in 1587; at this time, most of the Filipinos who disembarked from Spanish galleon ships were actually Filipino slaves or indentured servant escapees. The first established Filipino settlements were in Morro Bay, CA with other settlements cropping up in Louisiana by 1763 (Nadal, 2011). The second wave of Filipino immigrants brought *pensionados* or U.S.-government sponsored students to American colleges and universities in the 1900s after the Philippine American War of 1899 (Nadal, 2011). The last wave of Filipinos to arrive in the United States, from 1910 to 1940, was composed of Filipino laborers and nonsponsored students (Nadal, 2011).

The Caregiver Role

Family caregivers were frequently underpaid family members or relatives who contributed approximately $375 billion in cost savings for families each year (Collins & Swartz, 2011). Even if caregiving was associated with personal fulfillment, many caregivers admitted that caregiving in itself was associated with various physical, psychological, and financial burdens (Collins & Swartz, 2011). The current situation of caregivers and care recipients was characterized by increased levels of disability; increased duration, intensity, and burden of care; increased financial costs; and, a significant decline in the use of paid formal care (Collins & Swartz, 2011). With these difficulties, primary care physicians (PCPs) offered caregiver assessments. Caregiver assessments helped the PCP identify how high the level of burden the family caregiver perceived (Collins & Swartz, 2011). Caregiver assessments should aim to help the primary caregiver remain healthy while remaining focused on the care recipient. Caregiver assessments must also include an understanding of the context in which the family caregiver provided care to a loved one; the caregiver’s perception of the care recipient’s functional status; the caregiver’s self-perception of his or her current level of well-being; the challenges and benefits of caregiving; the caregiver’s perception of and confidence in his or her caregiving abilities; and, whether the caregiver needed additional help and, if so, at what level help is needed (Collins & Swartz, 2011).

Caregivers were encouraged to adopt the following measures to avoid burnout and to maintain their health: taking breaks, taking time to care for themselves, adopting a healthy diet, getting regular exercise, seeking preventive health care, joining a support group (even if the caregiver thinks that this is not yet necessary), and seeking or accepting respite care when offered (Collins & Swartz, 2011).

The use of web-based, assistive caregiving technology was credited with increased delivery of information to caregivers. This resulted in a decrease of depressive symptomatology as well as an increased sense of social support (Collins & Swartz, 2011). Additional supports for caregivers such as workplace accommodations (e.g. options for flexible scheduling and telecommuting) as well as provisions for financial reimbursement are currently being examined and, in some instances, implemented (Collins & Swartz, 2011).

Adjusting to the Caregiving Role. A study by Epiphaniou et al. (2012) indicated that family members and friends played a central role in providing physical and emotional care to ailing family members and friends. The caregiving role brought with it certain difficulties and responsibilities that differed from individual to individual. The issues associated with caregiving responsibilities included physical, emotional, psychological, social, and financial difficulties. Challenges of the caregiving role included uncertainty and distress in witnessing patient deterioration, difficulty finding the time to concentrate on personal needs, the need for emotional support, the need to minimize anxiety and frustration due to unreliable and irregular support, the need to be acknowledged, and the need to be prepared for the caregiving role (Epiphaniou et al., 2012).

Epihaniou et al. (2012) stressed that studies on caregiving are needed and are important in order to recognize the support needs, emotional needs, information needs, and psychological needs of informal caregivers; to improve the support given to informal caregivers; to help caregivers meet their needs and enhance their coping strategies; to identify effective support sources; and, to develop future interventions that will use an individual’s existing resources instead of external sources or external services that may be costly or ineffective.

In August 2011, the American Psychological Association (APA) acknowledged the importance of caregiving and caregivers by adopting as policy its Resolution on Family Caregivers. In this resolution, the APA stated several points, which included the following:

- It is expected that the number of caregivers will increase due to an aging population, which in turn will bring with it an increased incidence and prevalence of chronic health conditions.

- There is at present inadequate access, availability, and financial assistance for culturally sensitive, evidence-based interventions and services for family caregivers.
- There is an increased need for assessment and diagnosis of family caregivers' mental health problems and strengths in the context of culture, family, and community.
- There is an increased need for research practice collaboration for the translation of evidence-based practices into community-based, culturally-appropriate, family caregiver interventions and services. Family caregivers may experience considerable burden, stress, and disruption of their own well-being, employment, and educational and social pursuits.
- Caregivers may be at an increased risk for psychological and physical health problems, including premature or increased mortality, coronary disease, and stroke especially under conditions of high stress or strain (Commonwealth Fund, 2005).

Predicting caregiver burden. Kim, Chang, Rose, and Kim (2011) conducted a study that examined predictors of caregiver burden from a randomly selected sample population of adults from 7 different states. Kim et al. (2011) concluded that care recipients' functional decline was the most important predictor of caregiver burden. Sociodemographical factors such as age, gender, coresidency with the care recipient, and other caregiving-related factors either increased or worsened caregiving burden (Kim et al., 2011). The more impaired the care recipients were with regards to inability to complete tasks related to activities of daily living (ADL) and/or instrumental activities of daily living (IADL), also increased caregiver burden (Kim et al., 2011). Caregiver factors such as the greater number of hours spent caring for the care recipient also increased caregiver burden. This is due to increased dependence of care recipients on their caregivers, therefore resulting in an increased caregiver engagement and devotion to managing daily life for the care recipient (Kim et al., 2011). With regards to caregiver coping, the more coping strategies caregivers used, the greater the burden related to caregiving perceived and reported. This was especially true if emotion-focused coping strategies were used (Kim et al., 2011). Other coping strategies such as increasing the number of caregiver helpers did not decrease caregiver burden (Kim et al., 2011).

The Present Situation of Caregivers

The present situation and need for caregivers and caregiving. Beginning in 2009, there has been an increased interest in caregivers and caregiving. The American Psychological Association (APA) acknowledged the importance of caregivers and caregiving by adopting as policy its Resolution on Family Caregivers in August 2011. By doing so, the APA recognized that caregiving was a source of high levels of stress or strain on the individual caregiver. The caregiver’s well-being, employment, educational and social pursuits were therefore affected by the caregiving role, which included various activities as detailed in caregiver responsibilities (National Alliance on Caregiving, 2009). Caregivers also found themselves responsible for helping their care recipients with either/or both categories of caregiver activities, ADL and/or IADL.

Caregiving activities were classified into two categories, ADLs and IADLs. ADLs included getting in and out of beds or chairs as well as personal care tasks such as getting dressed, taking a bath or a shower, using the toilet, help for incontinence, and feeding. IADLs included: transportation, housework, grocery shopping, meal preparation, financial management, and arranging or supervising outside services. Other activities caregivers were involved in included: advocating for the care recipient and administering medical therapy or treatment.

Considering all these activities on the shoulders of individual family caregivers, it was no wonder then that caregivers were indeed at risk for physical and/or psychological health problems. This was especially true if family caregivers found themselves with these responsibilities for an extended period of time. Further description of the caregiver role and its effects on the individual family caregiver was discussed in more detail in the Review of Literature section.

Underutilization of caregiver services. Underutilization of caregiver services was an important issue that was also related as to why Filipino Americans were consistently underrepresented in Asian American studies in general and Filipino American studies specifically. Underrepresentation of Filipino Americans was also a reason why studies regarding Filipino Americans were sparse. As was mentioned in the first chapter, underrepresentation of Filipino Americans contributed to the perception that being Filipino American was being part of the invisible minority (Nadal, 2011).

Hong (2004) conducted a study where the main goal was to determine why Asian American caregivers had unmet service needs. Results of this study showed that aside from having unmet needs, caregivers in general had risk factors such as prioritizing self-sufficiency and family obligations, which predisposed them to having unmet service needs. These unmet service needs included but were not limited to the following: adult daycare, meal services, and personal care. Unmet service needs also arose due to a combination of personal, social, cultural, and environmental factors. Presently, there were major barriers to the use of supportive services by older minorities. These barriers included limited knowledge of cultural stereotypes and norms. According to this study, strong predictors of unmet service needs included: age, gender, functional status, health status, educational attainment, and informal support networks. Several themes also emerged from this study. These included: “being too proud to accept it (help), don’t want outsiders coming in, service was not available, bureaucracy was too complex, can’t find qualified providers, and never thought of it” (Hong, 2004, p. 251).

Findings from this study however, cannot be generalized to older Asian American caregivers because this study was conducted in a specific area or region. Additionally, Asian American minorities were differentiated from White counterparts only. Additional differentiation must also be delineated between service users and non-users among the Asian American caregivers in order to determine and confirm if there were different types of service barriers as well as different levels of unmet service needs (Hong, 2004). Another limitation of this study was the diversity of needs and informal support that Asian American caregivers received. Lastly, perspectives of caregivers were ignored in this study in the sense that unmet service needs were assessed by medical and mental health professionals and the care receivers instead of the caregivers themselves (Hong, 2004).

Studies that examined Asian American caregiver health in general were important in that, by critically analyzing Asian Americans' use of health care and supportive services, one can discover caregiver's perception of unmet service needs. Understanding the experiences of Asian Americans provided insights into the value and belief systems of Filipino Americans due to similarities between Asian culture and Filipino culture (Nadal, 2011). Additionally, caregiver health was an indirect indicator of the overall health of family members, in that having a healthy caregiver usually resulted in a healthy care recipient compared to a family situation where both the caregiver and care recipient were both in need of medical attention and care. Studies that determined reasons for unmet service needs may also help in overcoming personal barriers to the use of these services. This was a result of building mutual understanding and trust between service providers and Asian American caregivers (Hong, 2004). By determining Asian American caregiver service needs, service plans were tailored to these needs and policy makers and service providers were able to provide better and more accurate service to Asian American caregivers (Hong, 2004).

In the United States, Filipino American caregivers underused caregiving services such as home health care, respite services, and case management. The reasons for underutilization of services included but were not limited to the high costs of care, lack of awareness of available services, as well as unavailability of services (Kimura & Brown, 2009). Other noted barriers to service utilization of caregivers included socioeconomic status factors, discrimination, immigration status, lack of staff sensitivity to cultural issues, and benefit and service restrictions for immigrants (Kimura & Brown, 2009).

Implications for counseling and education

As with any other immigrant to the U.S., Filipino American immigrants found themselves contending with a new set of rules for living and working. With these new rules came new responsibilities and challenges. For the Filipino American caregiver, these responsibilities and challenges were even more difficult compared to the challenges that faced the Filipino caregiver in the Philippines (Nadal, 2011). As such, the Filipino American caregiver found themselves having to deal with the stresses of caregiving through different coping mechanisms. The processes of acculturation and assimilation were the basis on which mental health professionals gauged how effective Filipino American caregivers adapted to American society and culture (Nadal, 2011). Nadal (2011) stressed the importance of understanding the level of acculturation in working with Filipino American clients. Counselors cannot be expected to assess or treat all Filipino Americans in the same manner. It was more accurate to understand and apply the uniqueness of minority groups within minority groups to ensure therapeutic success (Nadal, 2011). Additionally, it was useful to note that in a therapeutic setting, Filipino Americans preferred social acceptance and emotional closeness; therefore, the ideal and most effective counselor for a Filipino American was a counselor who was personable, understanding, and aware of Filipino culture. This also lead to a more honest and trusting relationship between the Filipino American client and the Filipino American counselor (Nadal, 2011).

Summary

This chapter began with a brief introduction followed by details regarding the literature search strategy. The conceptual framework was developed using the Sociocultural stress and coping model (SSCM), the Caregiver Empowerment Model (CEM) and the COPE model. The SSCM was originally developed to examine the influence of ethnicity on caregiver characteristics, caregiving demands, appraisal of caregiving as either a challenge or a burden, the influence of cultural values on coping styles, and lastly, positive and/or negative outcomes of the stress and coping process in the context of the caregiving experience (McCallum et al., 2007). The SSCM provided insights into how ethnicity influenced how being a Filipino American caregiver impacted that individual's perception and appraisal of their current life experience as a caregiver, taking into account influences such as Filipino cultural values, social factors including gender, immigration and its effect on an individual's stress and coping methods (McCallum et al., 2007). The Mediterranean Model of Informal care was also mentioned as a potential influence on Filipino American caregivers, albeit indirectly, due to the history of Spanish Colonialization in the Philippines (del Pino-Casado et al., 2012). The review of literature concluded with a discussion of the present situation of caregivers, including the issue of underutilization of caregiver services by Asian American caregivers in general and Filipino American caregivers specifically (Hong, 2004; Nadal, 2011). The studies on caregiving that I read and analyzed so far were an equal mix of quantitative and qualitative methods. Specifically, the studies I noted for the social factors of caregiving, such as working and caregiving (Bainbridge et al., 2006; Kim et al., 2011; Losada et al., 2010; McDaniel & Allen, 2012; and Wang et al., 2010) were all quantitative studies. In contrast, the studies that I have read for the cultural factors that influenced the perception of caregiving, were qualitative studies (Jones et al., 2002; Scharlach et al., 2006); however, none of these qualitative studies used the phenomenological research method. It is anticipated that the results of this study filled the gap in the literature by examining the impact of the caregiving role through the unique factors of Filipino cultural values and life roles as experienced by Filipino American caregivers.

In the following chapter, I will present a more detailed discussion of how phenomenology helped increase the understanding of the Filipino American caregiving experience through a discussion of this study's research design and rationale, the role of the researcher, methodology (including participant selection and recruitment procedures), data analysis plan, issues of trustworthiness (credibility, transferability, dependability, & confirmability), as well as ethical procedures in the course of conducting this research study.

Chapter 3: Research Method

Introduction

The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino American experiences of the caregiver role. A study of Filipino American caregivers was needed to help fill the gap in knowledge regarding their experiences. Issues such as the difficulties and rewards associated with caregiving, as well as the central role family and friends have in providing care for an ailing family member must be examined further. This knowledge may lead to a more accurate identification of the needs of Filipino American caregivers. Additionally, this knowledge may help researchers better determine support sources as well as develop effective and culturally appropriate interventions and relevant health care policies for Filipino American caregivers (see Kataoka-Yahiro, 2010).

This chapter begins with a review of the research questions, followed by a discussion of the role of the researcher and methodology, which includes information on the participant selection logic and recruitment and data collection procedures I used. The next section of the chapter includes information on my data analysis plan and discussion of issues of trustworthiness, specifically credibility, transferability, dependability, and confirmability. A summary concludes this chapter.

Research Design and Rationale

The main research question for this study was, What is the lived experience of Filipino American caregivers? I also sought to answer two secondary research questions: How do Filipino American caregivers describe the personal impact of caregiving for their family members? and How do sociocultural factors impact the role of the Filipino American caregiver? Based on the main research question, I examined the central phenomenon which was the life experience of Filipino American caregivers. I also considered the effect sociocultural factors had on my study participants' lives.

I used a phenomenological design to answer the research questions. Phenomenology, as a research design, is recommended in situations where the goal of the study is to understand the meaning of individuals' experience of a particular phenomenon (Moustakas, 1994). The purpose of phenomenological research is to understand human thought and experience of a particular phenomenon as it is, free from bias and preconceptions (Converse, 2012). Husserlian or descriptive phenomenology is a process where the essence of a phenomenon is explored with the emphasis on rich, vital, and substantial descriptions of the experience of phenomena, not explanations nor analyses (Moustakas, 1994). Phenomenologists do not aspire to provide conclusions or generalizations as their end result; they are mostly concerned with providing a rich description of a phenomenon as it was experienced by an individual without further interpretation (Moustakas, 1994). The primary evidence of phenomenological investigation includes firsthand accounts of life experiences or the data of experience. This data also includes data which was thought of, intuited, reflected upon, and judged (Moustakas, 1994). These data were what made phenomenological data valid (Moustakas, 1994). If a researcher seeks a new insight into a particular phenomenon or event, phenomenology is used in order to find out the meanings ascribed to an event through a rich and detailed account and analysis of the incident being studied (Pratama &

Firman, 2010). The purpose of this phenomenological study was to gain an understanding of how Filipino cultural values and life roles affect Filipino American experiences of the caregiver role.

Role of the Researcher

Moustakas (1994) described the phenomenological researcher as a coparticipant in phenomenological studies. Together with the actual study participants, I became a coparticipant especially when the goal of phenomenology was reviewed. I had a goal to obtain rich, detailed, and substantial descriptions of my research participants' experiences of caregiving, from which meanings and ultimately, essences of life experiences were described (Moustakas, 1994). Inevitably, I ended up viewing caregiving through the study participants' perspectives or viewpoints. I set aside my biases and prejudgments prior to beginning the study in order to view the phenomena "naively" (Moustakas, 1994, p. 86), as if for the first time.

Epoche is the first step in the phenomenological research method. In this step, researchers try to set aside all their biases and preconceived ideas regarding the phenomenon to be studied (Moustakas, 1994). This is best done through "bracketing," which discouraged "knowing things in advance" (Moustakas, 1994, p. 85). Bracketing is a process where a researcher sets aside their biases and preconceived ideas regarding their study. Oftentimes, this may be done by writing down everything the researcher knows about the topic of their study, in a reflexive journal. This may include their personal reflections and questions regarding their study topic (Moustakas, 1994). Having prior knowledge and opinions about an event can interfere with a researcher's ability to gather new meanings from data gathered despite internal reflection (Moustakas, 1994). If I had prior knowledge of a phenomenon, I would have found it difficult for me (as researcher) to try and perceive a phenomenon as if I were viewing or experiencing it for the first time (Moustakas, 1994). I bracketed my opinions and information about caregiving in order to set aside my biases and preconceived ideas regarding this phenomenon. A more detailed discussion of epoche as well as the other steps of the phenomenological research method are found later in this chapter.

My personal interest in Filipino American caregivers stemmed from my experiences as a medical student and doctor in the Philippines. There, I witnessed resilience as well as devastation among patients and their caregivers. More recently though, I witnessed caregiving more closely when my mother and mother-in-law assumed this role. My mother had been taking care of my father for close to a decade while my mother-in-law had been taking care of my father-in-law for about a decade. Their experiences were quite different from each other, although there were some similarities as well. Seeing the experiences of my mother and my mother-in-law over the years prompted me to make the following assumptions: (a) I assumed that Filipino American caregivers were willing to become study participants; (b) I also assumed that Filipino American caregivers were willing to talk openly about their experiences as a caregiver; (c) I assumed the participants understood the following: what this study was about, the participants’ and the researcher’s roles, as well as the concepts of informed consent and privacy; and, (d) I assumed that participants spoke truthfully and candidly about their experiences related to my study (Varona et al., 2007).

Additionally, being of Filipino descent and having been reared in the Philippines prior to coming to America as a newlywed, I acknowledged that the following Filipino cultural values (Nadal, 2011) may have influenced how I interpreted the data collected in this study: the four fundamental Filipino values of *kapwa* (fellow being), *utang na loob* (a debt or norm of reciprocity), *hiya* (shame or loss of propriety), and *pakikisama* (social acceptance or conformity).

The participants were not known to me either personally or professionally. Despite this, one primary concern during this study was the avoidance of multiple and exploitative relationships. There was a possibility of these types of relationships to occur during the study, especially if I did not make my intentions and goals clear at the beginning of initial contact with the potential study participants. The Philippines is a country where great value is placed on relationships, therefore it was not uncommon for research participants to try and establish a relationship that differed from the researcher-participant relationship (Nadal, 2011). It was proposed that in order to avoid multiple and exploitative relationships, I must explain the study procedures and acquire informed consent from the potential research participants at the beginning of the study (Fisher, 2009).

Methodology

Participant Selection Logic

This proposed research study focused on the lived experience of Filipino American caregivers, through examination of sociocultural factors that had a personal impact on this experience in their lives. Nicholls (2009) stated that the more personal the research methodology, the smaller the sample size needed in order to achieve sufficient data saturation where no new information can be gleaned from the research participants. In phenomenological studies, Nicholls (2009) stated that it was common to have as few as five to eight participants in order to achieve data saturation. A purposeful sampling strategy was used in order to help select participants who had directly experienced caregiving (Moustakas, 1994).

In purposeful sampling, researchers looked for potential study participants who shared a common experience (Nicholls, 2009). From an initial group of participants who shared a particular experience, researchers then collect as rich and detailed an account as possible from those who were willing to speak about their experiences (Nicholls, 2009). Should an inadequate number of participants (less than five) result from the initial recruitment process, a snowball sampling procedure was used in order to allow recommended, eligible participants to get involved in the study (Suri, 2011). Suri (2011) described snowball sampling as a method that yielded “information-rich cases” (p. 69) as a particular study was conducted. In snowball sampling therefore, study participants were asked if they can refer additional participants to a particular study if inclusion criteria were met.

This study selected participants based on their willingness to participate in this study through the formal interview. In order to be included in this study, participants must:

1. be Filipino Americans either female or male;
2. be either a first or second generation Filipino American, who is at least 18 years of age;

3. be fluent in spoken and written English;
4. be caring for either a spouse or other immediate family member, or a relative with a chronic illness or disability that required supervision for at least 10 hours to greater than 20 hours a week of providing caregiving activities such as ADLs or IADLs;
5. Participants whose care recipient had passed away recently may be considered for inclusion in the study only if the care recipient passed away within 18 to 24 months of their caregiver's scheduled interview;
6. not be receiving payment for the care they provide their family member or relative; and lastly,
7. had been in a caregiving role for at least a year.

In phenomenology, rich and detailed descriptions of the phenomenon were sought in order to be able to determine the meaning and essence of a particular phenomenon (Moustakas, 1994). These descriptions were then analyzed and interwoven into a synthesis that assimilated the collected descriptions into a unified account of the essences of the phenomenon in question (Moustakas, 1994). It was estimated that a minimum of 10 participants, and a maximum of 11 to 15 participants was needed in order to provide a multi-faceted picture of caregiving as it was experienced by different Filipino American caregivers in unique ways (Converse, 2012). Nicholls (2009) noted that a small sample size such as five to eight was considered appropriate for the minimum number of participants required by a phenomenological study. When no new insights, information, or concepts were revealed by study participants, and when data analysis showed repetition of themes or key terms, then data saturation had been reached and the sample was thus considered to be adequate (Nicholls, 2009).

Potential participants for this study were recruited by reaching out to local Catholic Churches for information regarding pastoral groups, outreach ministry groups, and Filipino community groups that involved caregivers. I hand-delivered the flyers to these organizations to post on bulletin boards (see Appendix A). I spoke before a community outreach group meeting to explain and briefly describe my study. I left copies of my flyer with my contact information so that interested participants could contact me privately. A Letter of Cooperation (see Appendix C) was provided by the support group or Filipino community head. After briefly describing my study, I left flyers describing the study purpose, criteria for participation, and assurance of confidentiality of my study, as well as my contact information, in order for interested individuals to contact me privately either through e-mail or phone. Participation in the study as well as a mutually agreed upon interview schedule was confirmed by phone. The minimum number of participants was not reached through this initial recruitment procedure; thus, a snowball sampling procedure was used wherein individuals who agreed to participate in this study recommended other potential participants until the minimum number of participants was achieved (Suri, 2011).

Data Collection

In-depth, semistructured interviews were conducted with each participant in as relaxed, and informal environment as possible in order to encourage the research participant to share as detailed an account as possible of their experiences regarding caregiving (Moustakas, 1994). Distance became somewhat of a problem in order to conduct in-person interviews. These interviews were conducted by phone or Skype.

Interviews were also as interactive as possible, guided mainly by the stated interview questions. However, as the interview progressed related questions emerged that added to a rich and detailed description of caregiving. For this study, interview questions were related to the primary research question, What is the lived experience of Filipino American caregivers?, as well as the secondary research questions, How do Filipino American caregivers describe the personal impact of caregiving for their family members?, and How do sociocultural factors impact the role of the Filipino American caregiver? Because of this, I constructed the interview questions to be open-ended and broad (see Appendix B).

The interview setting was a neutral location that provided adequate privacy and confidentiality to all participants specifically a private study room in the public library. Some interviews were conducted by phone or by Skype, because of the distance between the participant's and my home. Prior to conducting interviews, an informed consent form was signed by participants. Permission was sought to audio record interviews in their entirety. This was also included in the informed consent form. I ensured confidentiality by assigning a code to replace the participants' names, which only the researcher knew. Interviews approximately lasted for an hour. Once all interviews were completed and prior to data analysis, verbatim transcriptions of interviews were made. Participants were given a summary of their interview data, as well as a summary of the data analysis, once it was done.

Data Analysis Plan

Phenomenology focused on rich, detailed descriptions of experiences and not on explanations or analyses of these experiences (Moustakas, 1994). This was to ensure that the phenomenological researcher was able to get to the essence of each participant's experience (Moustakas, 1994). The essence of a particular experience was defined as its universal feature or quality, without which an experience will not be the same (Moustakas, 1994).

In analyzing phenomenological data, Moustakas (1994) outlined four major processes in a phenomenological research study that helped in the analysis of the data gathered. The first major process was that of epoche. Epoche was also known as bracketing, where biases, preconceptions, and prejudgments of the researcher were bracketed or acknowledged and set aside in order for the phenomenon to become transparent to the researcher, thus revealing its truth to the researcher (Moustakas, 1994). By allowing transparency to the self, the researcher perceived their particular experience as if for the first time (Moustakas, 1994). This process was particularly important in phenomenology, since bracketing helped me to avoid advance knowledge of a subject or experience (Moustakas, 1994). Advance knowledge was considered to be based on outside influences, when what was considered to be essential data in phenomenology was supposed to be the result of internal reflection (Moustakas, 1994). Epoche also encouraged me to be open to other perceptions of a single phenomenon (Moustakas, 1994).

Epoche was followed by the process of phenomenological reduction (Moustakas, 1994). The main objective of phenomenological reduction was to be able to describe one's particular experience of a phenomenon using textural language, focusing on the qualities or features of that particular experience (Moustakas, 1994). One aspect of phenomenological reduction was the horizonalization of the individual experiences (Moustakas, 1994). Horizonalization was described as the process where the participant's account of their experience was treated as being equal in value along with other statements or accounts of other participants (Moustakas, 1994). Eventually, statements that were irrelevant to the research question or study topic were discarded, along with repetitive or overlapping statements, leaving the textural meanings and invariant components of the experience; the horizons (Moustakas, 1994).

The third major process in phenomenological research was that of imaginative variation (Moustakas, 1994). This process allowed for the construction of structural themes from the textural descriptions obtained from the process of phenomenological reduction (Moustakas, 1994). It also illustrated the interconnectivity of individual experiences and meanings of a particular experience (Moustakas, 1994).

The fourth and last process in phenomenological research was the synthesis of meanings and essences (Moustakas, 1994). This step was possible only after an exhaustive reflection on a particular experience (Moustakas, 1994). The goal of this final step was to present a cohesive view of the experience of a phenomenon by integrating the collected textural and structural descriptions of each participant (Moustakas, 1994).

In this research study, the specific steps that I used in analyzing the data that was gathered was based on Moustakas's (1994) modification of the van Kaam method of analysis of phenomenological data, which included:

1. Listing and Preliminary Grouping: This initial step of data analysis required a listing of every relevant statement or expression with regards to the phenomenon of caregiving. This step was otherwise known as horizonalization;
2. Reduction and Elimination: This next step separated the *Invariant Constituents* from the other expressions. Each statement was checked against two requirements; namely, (a) Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?, and (b) Is it possible to abstract and label it? Statements that fulfilled the above requirements were considered horizons of the experience, while statements that did not meet the above requirements were either eliminated or revised to express more exact descriptive terms. Statements that did not meet either requirement were considered the invariant constituents of the experience;
3. Clustering and Thematizing the Invariant Constituents: This third step resulted in grouping invariant constituents (of the caregiving experience) into different themes. This resulted in what was considered the core themes of the caregiving experience;
4. Final Identification of the Invariant Constituents and Themes by Application-Validation: In this step, I checked each invariant constituent and their accompanying theme against the verbatim interview transcription of each research

participant. I asked myself the following questions as I went over each transcription: (a) Are the invariant constituents and accompanying theme explicitly stated in the complete transcription?; (b) Are they compatible if not explicitly expressed?; and, (c) If they are not explicit or compatible, they are not relevant to the co-researcher's experience and should be deleted;

5. Using the relevant, validated invariant constituents and themes, I constructed for each participant an *Individual Textural Description* of the experience which included verbatim examples from each of their transcribed interview;
6. Next, I constructed for each participant an *Individual Structural Description* of their experience based on the Individual Textural Description and Imaginative Variation;
7. The next step was to construct for each research participant a *Textural-Structural Description* of the meanings and essences of the experience, which incorporated the invariant constituents and themes;
8. The last step resulted in a Composite Description of the meanings and essences of the experience, which represented the group as a whole (Moustakas, 1994, pp. 121-122).

Issues of Trustworthiness

Qualitative research methods had long been criticized for lacking the scientific rigor of quantitative methods. These methods had been described as being too subjective, as well as having information that was too detailed and too focused on too few subjects. They were also too easy to read, even anecdotal (Cope, 2014). In light of these criticisms, qualitative methods were evaluated using unique criteria; namely, credibility, dependability, confirmability, and transferability (Cope, 2014). In a qualitative research study, the measures of credibility, transferability, dependability, confirmability, and intra- and inter-rater validity replaced the quantitative measures of internal validity, external validity, reliability and objectivity, respectively.

In phenomenological studies, where the objective was not to generalize findings, transferability cannot be applied as a way to ensure trustworthiness (Curtin & Fossey, 2007). It followed in this study that transferability was not applicable because the findings of this study were specific to a small number of participants hence, it was difficult to demonstrate or show that the results were generalizable to different situations or sample populations (Curtin & Fossey, 2007). Related to this, dependability referred to the degree to which the study data can be replicated in similar situations (Loh, 2013). This indirectly implied that results of a study were replicable in similar situations, thus dependability was another measure of trustworthiness that was difficult to apply in a phenomenological study (Cope, 2014).

Credibility was the measure of how unchanged or constant a particular study's messages were in light of currently held knowledge or theory (Loh, 2013). Additionally, credibility referred to how true to their experience results from a study portrayed them, or their views, as well as the researcher's interpretations thereof (Cope, 2014). Loh (2013) stated that in order to strengthen credibility, the following techniques were used: prolonged engagement in the field, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy or archiving of data, and member checks. For this study, credibility was strengthened through triangulation and member checking. Triangulation was done through cross-referencing data collected from different sources, specifically, from the different individual interviews (Loh, 2013). Additionally, I listened to the taped interviews as well as reviewed the verbatim interview transcripts repeatedly in order to ensure accuracy of transcription and focus on the analysis of each interview. Member checking was another technique through which credibility was strengthened. Loh (2013) described member checking as a process where the final report of a study was shown to the participants in order to provide them with the opportunity to go over the report and provide additional insights or perceptions that were not interpreted as the participants had originally intended.

The last criteria that determined trustworthiness was confirmability, which referred to the degree to which the results of the study were corroborated or verified (Loh, 2013). Confirmability was a measure through which the researcher was supposed to show the flow of the research process, from how data was collected, as well as how data was analyzed in relation to the participants’ responses (Cope, 2014). Additionally, it was also supposed to present a rich and thick description of the participants’ responses with regards to their lived experiences (Cope, 2014). Conclusions and interpretations along with the methods to which they were arrived at was shown by the researcher to be derived from the data collected (Cope, 2014). Credibility and confirmability was strengthened in a phenomenological study by the quality of reflexivity as well as the process of bracketing.

Reflexivity was the researcher’s way of confirming their involvement in and development of the research process of the study (Cope, 2014). To this end, a reflexive journal was kept alongside all the data and steps in this proposed study in order to ensure confirmability (Loh, 2013). In addition to a reflexive journal, I made sure to bracket my beliefs and thoughts about this study, by acknowledging and setting aside my beliefs and other influences such as my experiences with Filipino culture, my biases regarding Filipino culture and caregiving, as well as what I currently knew with regards to Filipino culture and its influence on Filipino and Filipino American caregivers. By setting aside my beliefs, influences, and biases, I hoped to be able to present a rich description of the Filipino American caregiver from his or her perspective. All data was accessible only to me and will be kept in a secure location and will be destroyed after five years as per Walden University research protocol.

Ethical Procedures

Prior to initiating this study, Walden University IRB approval was obtained. The IRB approval number for this study was 12-27-15-0161249. Upon IRB approval, data collection procedures began. Flyers were distributed either through mail or by hand to Catholic Churches’ pastoral groups, outreach ministry groups, and Filipino community groups. These flyers contained a brief description and purpose of the study, assurance of confidentiality, right to cease participation in the study at any time without penalty, inclusion criteria for participants, as well as my contact number and personal e-mail address (see Appendix A). The research participants were not known to me, either personally or professionally.

Individuals who met the participant criteria and agreed to be interviewed were sent a consent form to review prior to the initial meeting, either through e-mail or regular mail. At the actual in-person interview, the consent form was reviewed, any questions were answered and the form was signed by the participants. The clause pertaining to the voluntary nature of the study as well as the clause regarding the right to withdraw or cease participation from the study at any time without penalty was explained.

Participants were briefed regarding how their interview data was handled, including how they were assigned a code to ensure their anonymity in the data collection process, how all material related to the interviews such as signed forms, raw audio from their interviews and written, verbatim transcripts of their interviews were kept in a password protected laptop, as well as a password protected portable USB drive, both of which were kept in a locked filing cabinet in my home office, of which there was only a single key that only I had access to. All written, audio, and electronic files will be destroyed after five years as per Walden University policy. Additionally, should any changes to any of the noted procedures be required, the Walden University IRB and the dissertation committee was immediately informed by the researcher through e-mail, prior to implementing any change in procedure.

Summary

This chapter began with a restatement of the purpose and research questions of this study. The central phenomenon being examined was the lived experience of Filipino American caregivers, as it was influenced by the sociocultural factors that had a personal impact on this experience in their lives.

This was followed by a detailed description of the study methodology, which included discussions and descriptions of participant selection logic, procedures for data collection, data analysis, as well as issues of credibility, dependability, transferability, and confirmability. This study utilized the phenomenological research method. Participant criteria included, (a) Filipino Americans who were either female or male, (b) who were either a first or second generation Filipino American, (c) who were at least 21 years of age, (d) fluent in spoken and written English, (e) who resided in the Southwestern region of Houston, TX; (d) who were caring for either a spouse or other immediate family member, or a relative with a chronic illness or disability that required constant supervision; (e) who were not receiving payment for the care they provided their family member or relative; and, (f) had been in a caregiving role for at least a year. After the initial screening, in-depth interviews were conducted at a neutral location where study participants felt at ease in talking about their life experience without fear of a lack of privacy or confidentiality.

Data analysis followed Moustakas's (1994) processes of epoche, phenomenological reduction, imaginative variation, and synthesis of meanings and essences. Specifically, I utilized Moustakas's (1994) steps in the analysis of phenomenological data. Issues of trustworthiness were discussed and included credibility, transferability, dependability, and confirmability (Loh, 2013). However, for this study, transferability and dependability were not applicable because these were measures that were dependent on the generalizability of the data or results gathered (Cope, 2014). Phenomenological studies cannot be generalized; first and foremost, because the sample sizes utilized in such studies were few, and the environment through which the study was conducted was so specific and unique to the participants involved that it was difficult to recreate the study using similar participants and similar environmental conditions (Curtin & Fossey, 2007; Cope, 2014). Therefore, this study focused on establishing credibility and confirmability instead. Credibility and confirmability both relied on the quality of reflexivity in order to present a rich and complete description of participants' lived experiences (Curtin & Fossey, 2007). Reflexivity was an indicator of a researcher's involvement with a research study, showing significant involvement in a study from its inception to its development, conduction, and interpretation (Curtin & Fossey, 2007).

Ethical procedures and considerations were then discussed. All forms of data, from the raw audio files, the verbatim interview transcripts, communications between the researcher and research participant, as well as results of data analysis and interpretation were kept in both paper and electronic form as files on a master external hard drive. Only the researcher had access to these materials as well as the laptop that was used in this study. These materials were kept in a locked filing cabinet in the researcher's home office, of which only the researcher had the key to. These materials will be destroyed after five years as per Walden University research guidelines.

Chapter 4 will present the findings of this study, including the setting of the study, the demographic information of the research participants, procedures of data collection and data analysis, the results of the data analysis in the form of identified themes and subthemes from supporting data in the participants' interviews. Lastly, evidence of trustworthiness and a summary will close the chapter.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to gain understanding of how Filipino cultural values and life roles affect Filipino Americans' experiences of caregiving. The guiding research question of this study was, What is the lived experience of Filipino American caregivers? The secondary research questions were, How do Filipino American caregivers describe the personal impact of caregiving for their family members? and How do sociocultural factors impact the role of the Filipino American caregiver?

This chapter begins with a review of the purpose of the study as well as a review of the central and secondary research questions. The next section of this chapter will include a description of the study setting as well as demographic characteristics of the eight study participants. This will be followed by descriptions of the actual process used in data collection and data analysis, evidence of trustworthiness, results of this study, main themes, and a composite description of the caregiving experience from the Filipino American caregiver's perspective. A summary will conclude this chapter.

Setting

Of the eight interviews I conducted, five were conducted in person while three were conducted via Skype due to my distance from the participant's place of residence. All participants met the inclusion criteria: (a) be Filipino Americans (either female or male); (b) be either a first or second generation Filipino American who was at least 18 years of age; (c) fluent in spoken and written English; (d) be caring for either a spouse or other immediate family member, or a relative with a chronic illness or disability, that required supervision for at least 10 hours a week; (e) not be receiving payment for the care they provide their family member or relative; and (f) have been in a caregiving role for at least a year. Caregivers could still participate in the study if their care recipient passed away within 18-24 months of the caregiver's scheduled interview. P1 and P8 were the only two participants whose care recipient passed away recently prior to their interview.

All interviews were completed without interruptions. There were no requests to withdraw from the study at any time. All participants denied ever experiencing any emotional or psychological stress during their interviews. All participants were given the opportunity to state any concerns they had regarding their participation in this study. I also gave them the opportunity to express whether they felt any distress as a result of participating in this study. I always paused between participant responses and the next interview question to allow participants to gather their thoughts or compose themselves if they remember a distressing memory. All participants were given a list of local and national toll-free crisis and counseling centers.

Demographics

Of the eight participants, only one was male; the rest were female. Two participants were retired. Four were nurses, and two were stay-at-home spouses/parents. Three participants were caring for a spouse, and four participants were caring for both parents. Only one cared for an ill adult child. Of the eight participants, two had care recipients who passed away before the participant's interview took place. The average age of all the participants was 55.

All participants were residents of the state of Texas at the time of the study. All participants were fluent in written and spoken English. The majority of participants (7 out of 8) were first-generation Filipinos who had come to the United States as young adults. P3 was the youngest participant as well as the only second-generation Filipino I interviewed. None of the participants received payment for their caregiving work. All participants have been caregivers for several years, ranging from as short as two years to as long as 13 years.

Data Collection

I initially attempted to recruit participants for this study by reaching out to pastoral groups, outreach ministry groups, and Filipino community groups from Catholic Churches within the Southwest region of Houston, TX. I hand-delivered study invitation flyers (see Appendix A) to these groups. However, I was rejected outright by staff of the local Church groups because they stated that they only worked with nonprofit groups and not individual students. I was allowed to post flyers on the community board in several community colleges within the Greater Houston area as well as in several local coffee and tea houses.

Interested participants contacted me through the contact information left on the invitation flyers. After meeting with interested participants who met the inclusion criteria of this study, I was invited by a prospective participant to speak at a meeting for a local Filipino community group which was not affiliated with any of the local Churches. At the meeting, I briefly described my study, detailing the study purpose, criteria for participation, and assurance of confidentiality. I also provided my contact information so that interested individuals could contact me privately either through e-mail or phone. The study site contact person signed the Letter of Cooperation (see Appendix D) and returned it to me at this meeting.

The data collection period for this study was from January to June 2016. The minimum number of participants was not reached after three months and a snowball sampling procedure had to be used. Individuals who had already agreed to participate in the study recommended other potential participants in order to meet the minimum number of participants.

Participant interviews were conducted at a location and time that was convenient for each participant. The duration of interviews was between 20 minutes to nearly an hour. P3 had the shortest interview (20 minutes) while P6 had the longest interview (about 57 minutes). Each interview went smoothly with no interruptions. I made follow up phone calls to each participant once transcriptions were completed to inform participants that interview transcriptions were complete and that a one-page summary of the interview would be e-mailed. All participants said that the summary I sent them was accurate and no clarifications were needed. All participants gave their consent to audio record their interviews. I digitally recorded all interviews using a Sony digital recorder, which had a removable microSD card. I made backup files of all audio interviews and the microSD card from the digital recorder used to record interviews was removed and kept in a locked filing cabinet, together with all printed transcripts and portable flash drives. I was the only one with access to this filing cabinet. There were no variations in the data collection process as I previously described in Chapter 3, nor were there any unusual circumstances in the process.

Data Analysis

The research data from this study was analyzed using the steps outlined by Moustakas (1994) for the analysis of phenomenological data. In phenomenology, since the researcher is the primary instrument in the data analysis process, I used epoche to set aside my preconceptions, biases, and prejudgments about the phenomenon of caregiving (Moustakas, 1994). To do this, I kept a reflexive journal with all my thoughts, notes, and questions related to my study. Through this journal, I managed to set aside or bracket my own beliefs, experiences, and knowledge with regard to Filipino culture and caregiving. To immerse myself in the data that I collected, I listened repeatedly to the audio recordings of the interviews as well as read and re-read the interview transcripts, often at the same time while listening to the audio recordings.

From the transcripts, I highlighted statements that were relevant to the caregiver experience in different colors, grouping similar statements or expressions. After this initial step, a list was made of relevant statements or expressions with regard to the Filipino American experience of caregiving. This is what Moustakas (1994) described as *horizonalization*.

The second step in the phenomenological data analysis process is that of reduction and elimination (Moustakas, 1994). Going over the initial list of relevant statements and expressions, I checked each statement against two requirements, (a) Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and (b) Is it possible to abstract and label it (Moustakas, 1994)? The statements that fulfilled both requirements were identified as the meaning units or horizons of the Filipino American caregiving experience, while statements that were repetitive, redundant, or not related to the research questions were eliminated (Moustakas, 1994). Statements that remained after this step were the invariant constituents of the Filipino American caregiving experience (Moustakas, 1994).

The third step involved clustering similar core categories and thematizing the invariant constituents into different themes (Moustakas, 1994). I clustered 55 initial categories into seven themes after examining each statement for being similar or recurring. A list of the final 54 categories and seven themes are presented in Appendix E.

The fourth step of the phenomenological data analysis process involved the final identification of the invariant constituents and themes by the process of application-validation. Each invariant constituent and their accompanying theme was checked against the interview transcription of each research participant, with the following questions in mind: (a) Are the invariant constituents and accompanying theme explicitly stated in the complete transcription?; (b) Are they compatible if not explicitly expressed?; and, (c) If they are not explicit or compatible, they are not relevant to the co-researcher’s experience and therefore should be deleted (Moustakas, 1994).

The next two steps of the modified van Kaam method used the validated invariant constituents and themes in order to construct an *Individual Textural and Structural Description* of the experience which included verbatim examples from each of the transcribed interviews (Moustakas, 1994).

The synthesis of a composite description of the meanings and essences of the Filipino American caregiving experience, with the goal of representing the participants as a whole, was the last step in the data analysis method (Moustakas, 1994).

Evidence of trustworthiness

Curtin and Fossey (2007) stated that phenomenological studies do not have the objective of generalizing findings. Because of this, transferability was not applied as method to ensure trustworthiness. In other words, transferability cannot be applicable because of the small number of participants included in this study. The small number of participants in this study made it difficult to generalize findings of this study to different situations or sample populations (Curtin & Fossey, 2007). Dependability is another method to establish trustworthiness in a qualitative study. Loh (2013) stated that this would be difficult to apply in a qualitative study, given the small sample size to which qualitative researchers are often limited. This is because it is indirectly implied that results of a study must be replicable in similar situations in order to be proven dependable (Cope, 2014). Nicholls (2009) elaborated that dependability is a measure of how consistently and accurately data was collected and analyzed in a qualitative study. Dependability can be established in a qualitative study if the researcher can provide an audit trail for the entire research process, especially for data collection and data analysis (Nicholls, 2009).

For this study, evidence of trustworthiness was established through credibility and confirmability (Loh, 2013). Credibility refers to how constant messages of a study are, compared to currently held knowledge or theory (Loh, 2013). Additionally, this also refers to how results from a study are portrayed, including how true and consistent researcher's interpretations are made (Cope, 2014). To strengthen credibility, I employed the methods of triangulation and member checking. For triangulation, data was cross-referenced from different sources. In this case, individual participant responses gathered through individual interviews were collected and analyzed (Loh, 2013). I listened to audio recordings of all the participants repeatedly, sometimes reading the interview transcript at the same time to compare accuracy of each transcript (Loh, 2013). Another technique I employed to strengthen credibility was member checking (Loh, 2013). For this study, I provided all participants the opportunity to go over a one page summary of their interview transcript. I instructed participants to go over each summary carefully and to inform me of any additional insights or perceptions, inaccuracies, and corrections they may detect (Loh, 2013). All participants were satisfied with the summary that was provided and no corrections or additions were made.

In terms of confirmability, Loh (2013) stated that this measure of trustworthiness refers to how well results of a study can be confirmed or verified. A qualitative study satisfies the measure of confirmability if an audit of the research process can be shown (Loh,2013). In this case, the steps that were used for data collection and data analysis are described (Loh, 2013). Additionally, I described the data analysis process in relation to the participants' responses, resulting in a rich and thick description of the Filipino American caregiving experience through the themes that emerged as a result of the data analysis process (Cope, 2014).

I also addressed credibility and confirmability through reflexivity and bracketing. Cope (2014) described reflexivity as a way that researchers can confirm how involved they were in the development of the research process of their study. In order to ensure the strength of the credibility and confirmability of my study, I kept a reflexive journal containing all the data and steps I had taken in my study so far (Loh, 2013). To be specific, I noted beliefs and thoughts that may influence my analysis of the data, including: (a) what I know and what I have experienced with regard to Filipino culture; (b) potential biases regarding the influence of Filipino culture on caregiving; and, (c) what I currently know with regard to Filipino culture and its influence on Filipino and Filipino American caregivers.

Results

In this study, an understanding of the Filipino American caregiving experience was gained through the study participants' account of their caregiving experience. Specifically, themes emerged that answered the main research question: What is the lived experience of Filipino American caregivers? The secondary research questions were: How do Filipino American caregivers describe the personal impact of caregiving for their family members? and, how do sociocultural factors impact the role of the Filipino American caregiver?

Themes were generated when at least five participants expressed similar views. The seven resulting themes are, (a) responsibility of caregiving, (b) impact of caregiving on employment status, (c) impact and importance of religion to caregivers; d) impact of Filipino heritage on caregivers, (e) impact of care recipient's illness on the caregiver and recipient, (f) resources for caregivers; and, (g) reflections on the caregiver experience. Specific quotations from study participants will exemplify each theme.

Discrepant cases

As the data from all participants were analyzed, there were two discrepant cases when it came to the theme of "Impact and importance of religion to caregivers". The first discrepant case was that of P6, simply because she was the only Church of Jesus Christ and Latter-Day Saints, or Mormon in the group. All the other participants (Seven out of eight participants) were Catholic. Furthermore, being a Mormon influenced her attitudes as a caregiver greatly because of concepts in the Mormon church culture such as compassionate service and the gospel culture. These two concepts encouraged P6 to accept the role of caregiver not just for her spouse, but also for others who need and ask for her help. The second discrepant case was that of P8 who was the only participant who stated that religion did not matter when it came to being a caregiver. P8 also added that as long as you have a caring or nurturing nature, you will feel the need to help.

Themes

Theme 1: Responsibility of caregiving

All participants described what activities were involved in the care of their care recipient. P4 stated that her parents mostly depended on the financial assistance she provided them. Most participants described their motivation for becoming a caregiver for their care recipient. P1 and P8 stated that they had to take over most if not all the responsibilities previously held by the care recipient.

- P1: I don’t have experience with caregiving. I don’t know if I was good or bad. In the beginning, it was just trying to help her up, making sure she doesn’t fall, feeding her food, and that became worse. You’re talking about from maybe 2005 to 2013. I was doing all of that. And then there was the showering. Until the people from Medicare came to shower her, all the hygiene, I was the one doing all that. Until I got that caregiver I was talking about, it was extremely difficult, because I’m doing everything. I took that role. You know, shopping, cooking.
- P2: I have to make sure that he has food to eat because I have to go to work. Make sure everything that he needs is there. I give him his cell phone so he can call me anytime he needs anything. There’s nobody else who will do it. As an individual, it is your responsibility to take care of everybody. Siblings, parents, even the extended relatives is your responsibility. That’s how we were brought up.
- P3: We had to make sure the kids were taken care of as well as, he was taken care of. We had to make sure that that was all in place, aside from his therapy, and also my business that I run. And then also, making sure that all the insurance, all the medical bills, and all the doctors and all of that were being taken care of.
- P4: They don’t need a lot of caring because they’re independent. Most of the time, I cook, I take her to work if my dad can’t. We help them financially. We take turns taking care of them. I just want to take care of them. They took care of me as a child and I just don’t want them to do anything but relax, enjoy themselves. It [P4’s roles or responsibilities] didn’t change much because I was still able to do everything that I need to do.

- P5: I would just help them when they need to go to the store to buy, get something for their medical appointments, and also sometimes they just want to talk to somebody. Growing up they took care of us so, that’s why I told my mom and dad, “I’m gonna take care of you”.
- P6: Oh, when he wakes up in the morning, gets his blood pressure and blood sugar. And then, I give his first medicine, which is the Levothyroxine and then, I, before he eats breakfast, and then after 30 minutes or an hour, he can take his breakfast. That’s the first thing that I do in the morning. And then, of course after breakfast, I give him his medicine and hour or two after breakfast, I again take his blood sugar reading. I have to give care to my husband. And to relatives and friends, compassionate service as I call it and it’s one of my roles as my brother’s keeper.
- P7: She’s actually more self-sufficient. She wakes up, she checks her sugar, she checks her blood pressure, and she charts them every morning. And usually, we make coffee in the morning. She helps me to prepare food like, she would cut up stuff she would want me to cook…Having a full-time job and caring for my mom, caring for other stuff as part of being a wife and mother you know. It’s kinda like too much sometimes. But I try to provide for her and meet her basic needs – specific needs for her like, take her to the doctor, her doctor’s appointment, make sure she has all this medication, make sure she takes some time in that direction. Emotion-wise, sometimes I cannot meet all the emotional needs of my mom.

It's my responsibility, because I'm the only girl to do that. My other brothers, I don't think are able to care for my mom. Nineteen years ago, she came to live with us. She took care of my children, she took care of my family. She helped me raise my children, so I guess it was my, my duty to return the favor. Overall, I guess I could rate myself as a good one, but not the best one. It's hard to just be the one.

- P8: I really, practically didn't have to do so much. Taking care of her did not require much, except the usual like, we would have to bring her food up to her bedroom. Maybe assist her, escort her to the washroom if she needed to go to the washroom. But that wasn't often either. It was more the psychological make up that I had to watch out for and the diet, and the whatever decision she had to make for the household, that she couldn't manage to do. I think it's natural for a mom like me to try to encompass almost everything that had to do with her. Because there were – majority of the things that she couldn't do anymore like, running the household, telling the help what to do. I'm not as strong as her. What drove me was the fact that she was of my flesh and blood. It's my love for her.

Theme 2: Impact of caregiving on employment status

All participants described how they had to adjust to the added role or responsibility of caregiver to their care recipient. P1 stated that he had to quit his job in order to spend time with his wife. P2 verbalized that she could not stop working and that she had "nothing left for herself". P3, P5, and P7 noted having a flexible place of employment that enabled them to take care of their care recipients.

- P1: The moment she was diagnosed, I quit my job basically…to spend time with her…
- P2: You know you have work to take care of and there's nothing for yourself.
- P3: His job did hold his position for him, until he was ready to go back. He was on long-term disability for a time. I'm thankful I do have a job that gave me the flexibility to be able to make the phone calls during the day that I needed to make, to you know, make sure that wasn't happening.
- P5: I'm working full time and a graveyard shift. I'm a NICU nurse. I had to take time off work because my dad requested that I go with them.
- P7: And because my job is very flexible, I could go and check on her, and see if she's doing okay, and then I go back to work.

Theme 3: Impact and importance of religion to caregivers

P1 told me of how he had to work with the Church to accommodate his wife, especially when it became difficult for her to go to Church. P2 reflected on how faith enables her to be "pulled to where you are needed". P3 verbalized how faith was important for her especially after her husband suffered a stroke. P4 and P5 reflected on the Commandment to "Honor your father and mother", that motivated them to take care of their aging parents. P6 had the most anecdotes to share with regard to how her religion has motivated to care for not only her care recipient, but also of other people. P8 was a discrepant case in that she was the only participant who stated that religion "does not matter" in the sense that what matters is whether you have a nurturing character or not.

- P1: I bring her to church for about two to three years until it became difficult for her to go. I worked with the Church, so that they can eventually put a handicapped sign.
- P2: Our values is determined by what religion we practice. When you have faith, you are being pulled to where you should be. Pray together. Yeah. Yeah. I think that's something that's very important. For the family.
- P3: We rely heavily on faith, especially right after it, the stroke, happened. We asked family and friends to pray. With just a little bit of faith and hope, and know that it will be okay.
- P4: Most Filipinos are Christians so our lives are based on that. Commandment #4: Respect your parents. Honor your parents. It's also religion that can affect your relationship with your parent.
- P5: You have commandments that says/said, Honor your father and mother. You just have to like, do what you have to do for them. You have to love them, take care of them. Like what Christ said, "Be a servant before you could be a master".
- P6: We are our brother's keeper. As a Christian, it is our moral obligation to help one another. I belong to the Church of Jesus Christ and Latter-Day Saints. Yes, I'm active in Church. I have a calling in Church. I'm very active. I was called to be a visiting, teaching coordinator. Every month, sisters in the church – we call it the Relief society, will visit – we are assigned to visit sisters. Each of the sisters – we call them visiting teachers. In the Church, we do Compassionate Service. If anyone among our members needs help, whether a male or a female, we respond

to that. We’re not being paid. We just give our service. We have to care for our brothers and sisters. That is His commandment. To love one another. We have what we call in our Church, the Gospel culture. Whether you are in the Philippines or here in America, we have one doctrine to follow. Gospel culture means, we have to care for our brothers and sisters. Anywhere you are, whatever you’re doing, if somebody here needs help, you have to give help. Well it’s easy because how I look at it – you do it out of love. It eases the burden. When you love the person.

- P8: I think if you have a nurturing character, it really doesn’t matter that you’re Catholic. It’s really in you, if you’re a caring person. Something will make you feel as though you need to help, whatever your religion is.

Theme 4: Impact of Filipino heritage on caregivers

All participants spoke of the importance of keeping close family ties as the reason and motivation for caring for their care recipients. It is the Filipino cultural value of keeping close family ties that ensures that there will be someone to care for elderly family members. This is therefore a valuable resource for caregivers.

- P1: I was raised in the Philippines. It is the custom of Filipinos, of being close to relatives and helping relatives. It’s what you learn growing up. Taking care of the sick is a cultural value in the Philippines, particularly relatives. If I was in the Philippines I would be a lot better because, you have more relatives you could depend, depend on.

- P2: I grew up in the Philippines and I came here in 1992. We were brought up to be caring, to be considerate, respectful, and most of all, to love family. Old people grow old and die with us. That's how it is in the Philippines. We don't send our parents, or our grandparents to anywhere. We take turns in taking care of them. Life in the Philippines is different. In the Philippines, you have help. You have your maids, to assist you. Here in America, you do everything. So that makes it even more difficult. I teach also the kids to give more time, if they have time to spend time with them, grandparents. Some of the children, when they're out of school or when they don't do anything, they stay with the grandpa. We, with my husband, work together so, we do it, care for care recipient, as a family. I would rather get somebody from the Philippines, or a relative to help me take care of my elders. The best caregiver is like someone who you know. A relative.
- P4: I was raised in the Philippines. My family is very close. It plays a big role in morals. Being raised in the Philippines is different from being raised here. Unless the family and the parents instill the moral values, our moral values to their children when they were young, if they were raised here. And when they were growing up, even just for two years, my parents instilled in them Filipino values. My kids were raised here. My kids were born here. Even when they were still in the Philippines, we keep close contact. It's part of the culture to take care of the parents. You can't just put them in one place and forget about them. I don't want my kids to do that to me.

- P5: My aunt and my mom took care of my grandpa. He stayed with us for a while, like, four years! It's part of our culture that we have to – it's probably a self-sacrifice, gratitude, and you know, we just – we just have to take care of them. We're very patient? That's why we could take care of them. Because others, I don't think they have that trait in them. That's why they would just send them here (nursing home). I think it's just part of being a Filipino that when you see them, even like, your parents, your grandparents, and we are an extended kind of family.
- P6: The Filipinos are very family oriented. The family are closely knitted to one another. That's how Filipinos are. Whether you be a Filipino or whatever nationality, whatever race you are, we follow this Gospel culture. We are in the Church, we are this one, big, happy family. One big family. We are all brothers and sisters.
- P7: Yes, me and my husband. My husband is also a nurse, so if I'm not there, he's there. If she needs something during the day, she will call me.

  So being born from my country, the Philippines, of course it affects my respect, my caring for the elderly. The older you get, the more respect you get. Wisdom comes with age. Seeing how my parents took care of their parents. It's also embedded in our culture that after you grow up, you're supposed to look after your parents as they grow older. You're supposed to care for them in their old age, as part of our culture. That's what's been happening when my grandparents had grown old. My mother used to send money or something for them. And then, when she was still in the Philippines, she would go out and take care of them. Not all children do the same thing. I still get some people who shirk their responsibility.

- P8: The Filipino culture is different. It's one thing that you automatically accept and assume the role of caregiver even for less serious illnesses. You are expected – No, it's not demanded of you, but your family, your children, have families of their own already. They expect you to have a role in running the – I mean in participating in their everyday life. If they need assistance in other – you know, in any other form of assistance, we already – as parents, we accept that already, that they can depend on us.

  I was raised in Manila. The girls in the family all have a nurturing character. Two of my older sisters took care of our grandmas. There are other aunts who also depended on my older siblings to care for them.

Theme 5: Impact of the care recipient's illness on the caregiver and recipient

Much of the impact of the care recipient's illness on both the care recipient himself and their caregiver has been described as difficult. P4, P5, and P7 have stated that their care recipients are not that difficult to take care of but accommodations still must be made occasionally, depending on the situation, such as when their family travels. P2, P5, and P7 also described how their care recipients' personality seems to have changed as well, becoming needy, clingy or even impatient at times. P8 had a lot to say with regard to the impact her late daughter's illness (metastatic cancer of the breast) had on herself, her daughter, and their family. P8 was the only participant who detailed her daughter's pre-cancer and post-cancer impact on the family. Prior to being diagnosed with cancer, P8 described that her daughter was active in her children’s school activities and was generally a positive person. As P8’s daughter’s condition worsened however, P8 noticed that she was starting to fear that her daughter would eventually “leave them”. She admitted that she had to start preparing herself for the worst, for the sake of her grandchildren. She also stated that her daughter’s cancer diagnosis caught them by surprise, and that basically, they were caught off guard by the illness and her daughter’s eventual turn for the worse. P8 noted that her daughter was still in denial with regard to the gravity of her illness, which P8 thought was made evident by her daughter’s wish to keep her condition private.

- P1: It was a losing battle, because nobody survives PSP. The problem is the mind does not deteriorate much. She can’t do much around the house anymore. About four or five years before she died, she could not talk anymore. Communication was hard. At some point, I don’t think she can see very well. Feeding was also an issue, since it would take an hour and a half. She refused a PEG, she also refused a feeding tube. So it was manual. It’s brutal. You would not even wish that on your enemy. My wife, she, she fought the disease till the very end. I’m proud to say that...seeing her deteriorate and feeling helpless…Seeing your wife suffer and she cannot do anything. Life expectancy with PSP was seven and a half years, and she lasted 12 years.
- P2: Sometimes when we have to travel, he has to be in a wheelchair. He cannot tolerate walking after the knee surgery. I think when they are sick, they become

like, needing more attention. They become different when they're sick. They become impatient too.

- P3: He walks with a cane. He's proven them wrong that he wouldn't walk again because he's walking and he's doing well. There was a window of time where we didn't really know what the outcome was going to be. There was a possibility he – may not be able to walk again. I would say the most difficult thing is standing my ground and knowing what would be best for him and my family.
- P5: They keep on repeating and repeating. They don't drive. There's no public transportation over here. They get bored of course. I would pity them. They're just in the house waiting until someone comes to pick them up. They don't want to obligate others. They would say, "We are not their responsibility". They would just stay in the house. Yes, sometimes they are very needy. It's hard for them to adjust because they're old. You cannot teach an old dog new tricks. It took us years to adjust to this system here and we're still adjusting.
- P7: I think as they grow older, *nagiging makulit*, become annoying. It's typical that the older people don't believe you sometimes. She uses a cane, she has shower pans. She has a bedside commode. Whenever we go on vacation, we always need to consider her. We have to tailor our activities to her since we cannot leave her. Other times, we have to change plans because of her. If we cannot take her, we cannot take her. Because if you don't take her, she's like *kawawa* or pitiful. It slows us down. Actually, my mom is easy to take care of – it's just the repetitive requests that bothers me.

- P8: We were also happy that her condition did not really deteriorate until about two months before she actually passed. She was very active at the time of her diagnosis, she was always involved in school activities of her children. She was of positive nature, all the time. She wasn’t the type who would get sad at her condition. She tried to take care of herself as much as she could. All the way to the last minute.

  You – as a mom, you have your own fears, when your daughter is diagnosed. I have a feeling at the very start, that she eventually would have to leave us because of the kind of cancer she had. Part of the psychology that I had to adopt was to be able to accept that even if I knew that. We were all praying and hoping that she would last long and she would recover. I had to prepare myself just in case, for the children’s sake. None of us could show the least amount of fear. We had to show that we were like her. Everyone would be consistent. This thing was really a shock to us. There were no plans, no well-laid plans in case someone in the family got ill of this kind of magnitude.

  Her immediate concern was not let them know how serious her illness was. My daughter never shared anything negative about her illness. She was really going downhill and not improving at all. From the time of her diagnosis, she only had nine months of…remission, after which the cancer already spread. That was the only part…where she displayed frustration, disappointment, and sadness. The whole time, up till the time she passed in 2015, she was a fighter. It was a great help to the members of the family, the people around her, to not see her depressed, to not hear her share her pain – physical or otherwise that she was undergoing. Nobody could really tell the extent of her illness, up to the time she was rushed to the emergency room of the hospital, on the day before she died. We could share the strength we had to each other. What propelled her, what gave her the strength, were her two children.

You just think of how your present relationship, the here and now, the fact that she's your daughter and she's ill, affects you already that heavily. She placed her life in their hands. I also trusted them because of their reputation. They wanted her to handle her illness by – to a certain extent, by accepting her true condition. Because till the very end, she thought she would live. She thought she would recover. I noticed there were times when she would be in pain and she would deny it. I wouldn't believe also that she wasn't feeling anything, 100% all the time.

Theme 6: Resources for caregivers

Most of the participants mentioned resources they needed to include financial resources (insurance, food stamps, social security) and services (home health, other caregivers, physical therapists, respite care). Other participants considered their family members, relatives, and friends as resources in that they were an additional source of help when needed.

- P1: I would get a caregiver for two to three hours when I have to play tennis. Two persons is needed for her care. I was the only caregiver until 2011. You're busy trying to manage the care, because she has people coming in, helping, part of

Medicare, who give her a shower. I think about once a week, they come in, the social worker comes in, the preacher. The other caregiver was someone we hired from the Philippines. She turned out to be like a daughter. She lived with us for a period from when she came in 2011, until she left. The caregiver was doing the feeding. So, she was doing it slowly, using the spoon and baby bottle for water. Some friends will babysit, sit with her, visit her. My wife's half-sister was here six months out of the year and that happened for about three to four years. She was really helpful. I get to talk to somebody too. Later, she got into hospice care at home.

- P2: He's getting the SSI and food stamps. He has insurance now, Medicare so, that's a BIG help to us.
- P3: I would say the biggest resource that was not just for me but for everybody was assistance navigating through the insurance system. And medical billing. It's just so, there were more than a couple of instances where the bills were coming from different places so, if I hadn't stayed on top of it, it would've been easy to double pay.
- P4: They stay in our house so, basically, they don't spend anything except for when my mom wants to go and buy some stuff. They just started receiving social security last year.

  But for me, I'm not satisfied. Yeah, I still wanna help more. Sometimes I'm thinking, "What if that's my dad? How am I gonna take care of him"? My sister's a nurse so, I think it's better. "You do it! You're a nurse. You know what to do".

My brother and sister are my other resources. They [P4's parents] have been hopping from my brother, to me, to my sister. Their caregivers are overwhelmed, they put them in a facility. Just for five days, just to take a break. But I – I don't think so [Gestures to herself and shakes her head no.].

- P5: Most of the time, it's me. If I need help, then I go to my sister. I really had to tell my sister, "I need help". Cause could not do this on my own.
- P6: He had a home health nurse that comes once a week. He used to have a physical therapist for about – three months. They would extend a helping hand on how they could help me. So, that is a relief. Hearing words like that gives me comfort. There is someone caring for you too.

  The insurance is taking care of his expenses. I mean like, medicines, doctor's visits. In the Philippines, it's a very different situation. You really have to have something. Before you can get the best medical attention that you need. Just the operation itself, it cost us – if I remember correctly, half-a-million pesos. So, putting all together, all our hospital expenses, all our – all his medical expenses, we spent – this is no exaggeration – around 3.5 million pesos. We never put him in an institution. He is always a private patient. It really cost us a fortune. That's why when he died, he left us with almost nothing. Just his paintings. Because he was about to do a one-man exhibit.
- P7: The doctor sees her every week at the wound care center and the home health comes and takes care of that so, that's the support that I appreciate. Then she goes to her doctor once or twice a year to renew her prescription and stuff like that. She

has some social security income. She also has some money before then. She can sustain on her own. She has Medicare, she has Medicaid. But for right now, she is okay.

Respite care is more for people who are overwhelmed already, so they need their rest. You actually need to have like, a release? Or somebody would take over when you are getting burnt out.

- P8: First we had to eventually find nurses who lived in the neighborhood, who can help us when she had to be administered with intramuscular injections. There were occasions when we needed to look for her medicines elsewhere because some of those medicines. The biggest drugstore in the Philippines would run out of that particular medication. We had to go straight to the supplier.

  We knew that if my son-in-law would concentrate helping out my daughter, it meant the other members of the family should help with the other expenses. Eventually, I had to help already with her treatment. Second, how modern the equipment are in the hospitals that you go to, maybe the members of the pathology team were depending on the results from the equipments that were used to diagnose her.

Theme 7: Reflections on the caregiving experience

Much of the participants' reflections on their caregiving experience noted the difficulty of the entire experience, the amount of stress involved, coping strategies that made certain things easier for them, and how love for your family is a powerful motivator.

- P1: At the time, I was being tested. When I look back I always think, “Oh, I should have done this or that”. Caregiving is an experience that, looking back on it now, you think, “How did I get through it”? But I’ll do it again for my wife. I know I tried my best. I think I did as much as humanly possible.
- P2: Even if there’s a lot of hardships, when you think you’re doing it for the loved one, then it makes it easier. No matter how much the burden is, plus it keeps you going. The way you perceive yourself as a caregiver and how well you take the responsibility. If you are just being forced to do it, that’s another thing. But if you love the person that you are taking care of, I think it gets easier. It gets difficult but it’s just how you handle things. It’s how you schedule your time. It’s how you delegate the task. Right now, it’s better because, with my father-in-law, my kids are bigger now.

  If I am overwhelmed, I just go to the Church parking lot and cry it out. Because it gets overwhelming sometimes. I became stronger, I learned how to manage my time. I learned how to be more understanding, more patient. Sometimes I delegate. Boost their morale. Get them on their feet as much as possible. Don’t be too dependent. Maximizing what they can still do and then, letting them think they can do it. Transfer to them the positive outlook, letting them identify their strength. So they don’t feel too helpless or that they don’t matter anymore.
- P3: When he needed assistance the most, it became a priority. It was still a balancing act, trying to make sure that everything else was still going on. But not too different from being a mom. I would say the most difficult one would be the

balance of helping him, yet also allowing him to figure out the things he needed to gain back his independence, of being able to do things, and learning from his cues of when he needed assistance. And really, just staying on top of things: the doctors' appointments, the medications, things like that. I really think that some of the skills that I've earned as a mom throughout the years really helped because I think, through the process, I was able to give him the room that he needed to recover, but also in the same respect, still be there and get things done.

We've always been very grateful for what we have, not necessarily the material things, but the people around us and experiences around us. As a family, the 6 of us have really grown closer. I think the experience itself has taught me that I could overcome this type of thing and it's taught me that my husband has the will. It was all him you know! His positivity and his strength to get through it. That's taught me a lot. I think having a care recipient who has a positive state of mind makes a big difference for the caregiver and the amount of stress the caregiver will have.

- P5: It's stressful. They don't know what to do and like their limitations, those stuff like, they couldn't go out where they want to, they have to wait for you for their appointments. It's stressful but it's worth it. I'm not perfect but we just try to care for them the best that I could. Even I could not tell if it made a difference. At least you know you have food on the table, your house is always clean. But on the other side, you have to hear them complain…It's a balance and sometimes, it gets out of hand.

Everything in life you know, it influences how we deal with people. You always have to plan, sometimes you get fed up too. Just let them enjoy. They're old. Let them do what they want. I just want them to experience what I have experienced. But taking care of them, it's not easy, it's not a joke. It's challenging. It helps you grow up as a person too. At least they're here, if you need some guidance, they're here. They might think you're not listening or hearing them out. But you know, deep inside, you're trying to process all this to be a better person.

- P6: It's not even a burden. It's part of your learning. Your growth as a person. Because your knowledge is being increased on – if you are doing it – an on-the-job training. I'm happy with what I did. No regrets. If you are just after the compensation, I believe you cannot do the work well.
- P7: There's still more room for change and improvement. It's not easy to be a caregiver until you experience it.
- P8: My life has changed but this is mainly because I saw some very disappointing developments during her illness.

Composite Description

For this study, the last step of the modified van Kaam method of data analysis involves a composite description of the caregiving experience, using a synthesis of the themes generated from the semi-structured interviews (Moustakas, 1994). The goal was to present a meaningful description of the lived experience of the Filipino American caregiver. The following is the composite description of the experience of Filipino American caregivers.

All participants described their caregiving experience as a responsibility that consisted of several tasks, with some participants indirectly saying that the amount of activities that needed to be done to care for their care recipient was such that they either had to stop working or have a flexible job that would allow them to take time off to care for their care recipient should the need arise. Some participants expressed that taking over most if not all their care recipient's former roles or tasks added to the difficulties of the caregiver role. P2 even verbalized that she had "nothing left for herself" at the end of the day.

When speaking of their motivation for caring for their care recipient, seven out of eight participants verbalized the impact of religion on their motivation through: following the commandment to Honor thy father and thy mother (P4, P5, & P6), relying on faith in difficult times (P2 and P3), working with the local church to help make your care recipient comfortable (P1). P8 was the only one who expressed a discrepant view when she stated that religion did not matter when it came to motivation, because she believed that having a nurturing character matters more in that it made you feel like you needed to help. All eight participants also considered the impact of Filipino heritage on their caregiving experience. All participants stated they considered the Filipino cultural value of keeping close family ties and respect for the elderly as motivation for caring for their care recipients. All participants stated that they were brought up to care for their other family members and especially their elderly relatives. All participants consistently stated that Filipinos have close family ties. All participants considered family, relatives and sometimes even friends as important resources for additional help in caring for their care recipient.

Reflecting on each of their care recipient's illness and how it has impacted their lives, most participants considered the entire experience as difficult not only for them, but also for the care recipients themselves. Some of the difficulties participants enumerated included, the severity of the care recipient's illness itself, some changes in the care recipient's personality such as becoming needy or clingy, and adapting some accommodations for the care recipient especially when travelling. P8 had the most to say regarding the impact of her care recipient's illness on her and her family, especially when it came to the resources they needed.

Because of the difficulties most if not all participants faced when caring for their care recipient, participants considered the resources they needed most were financial resources, such as insurance, social security income, and food stamps; as well as services, such as home health, physical therapists, respite care and other caregivers. It is also because of the difficulties they faced in caring for their care recipients that caregivers reflected on their experiences as difficult, strategies they needed to adopt in order to cope with everyday stress, and of how love for your care recipient makes the whole experience easier to bear.

Summary

The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino Americans' experiences of caregiving. The participants' descriptions of their experiences answered the guiding research question of this study, which was: What is the lived experience of Filipino American caregivers? Participants' descriptions of their experiences also answered the following secondary research questions: How do Filipino American caregivers describe the personal impact of caregiving for their family members? and How do sociocultural factors impact the role of the Filipino American caregiver?

In this chapter, I discussed the data collection and data analysis procedure in detail, evidence of trustworthiness, and the results and themes of this study. I also included in this chapter, quotations from the participants that resulted in an in-depth account of their experiences. I analyzed all data by hand coding, with no dependence on any computer software for qualitative analysis. I used the modified van Kaam method as described and discussed by Moustakas (1994). There were seven themes that emerged from the analysis of the data collected in this study: (a) responsibility of caregiving, (b) impact of caregiving on employment status, (c) impact and importance of religion to caregivers, (d) impact of Filipino heritage on caregivers, (e) impact of care recipient's illness on the caregiver and recipient, (f) resources for caregivers, and, (g) reflections on the caregiving experience.

In Chapter 5, I will revisit the purpose and nature of this study. Then, I will compare an interpretation of the meanings and findings of the data collected to the peer-reviewed literature as outlined in Chapter 2. I will also discuss my study's limitations concerning trustworthiness, recommendations for future research, implications for social change, theoretical implications, and practice recommendations. The summary and conclusion of this study will close Chapter 5.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino Americans’ experiences of caregiving. Although the need for caregivers has been increasing, researchers have not conducted enough studies that focus on Filipino American caregivers and their experiences (David & Nadal, 2013; Kataoka-Yahiro, 2010; Kimura & Browne, 2009; Nadal, 2011; Varona et al., 2007). I found a gap in the literature regarding the lived experiences of Filipino American caregivers and how these experiences are influenced by their cultural values and life roles.

I collected data for this phenomenological study by conducting mostly in-person interviews with eight participants who identified as Filipino American caregivers and who fulfilled all of my other inclusion criteria. I conducted three video interviews via Skype because of the long distance from my home to the interviewee’s home address. I used a purposeful sampling method as well as a snowball sampling method after I determined that the number of participants was insufficient to achieve data saturation.

I used the van Kaam research analysis process as modified by Moustakas (1994) to analyze collected data. After using the modified van Kaam data analysis steps, seven themes emerged that were based on the central research question. The seven themes included, (a) responsibility of caregiving, (b) impact of caregiving on employment status, (c) impact and importance of religion to caregivers, (d) impact of Filipino heritage on caregivers, (e) impact of care recipient’s illness on the caregiver and recipient, (f) resources for caregivers, and (g) reflections on the caregiver experience.

In this chapter, I will explain my interpretation of the study findings related to the themes and conceptual framework initially discussed in Chapter 2. I will describe the limitations of this study, recommendations, and implications of this study in the remainder of this chapter. This content will be followed by a concluding section.

Interpretation of Findings

Overall, findings from this study validated the literature I discussed in Chapter 2. The interpretation of findings follows. First, I will present the findings by theme as compared to the review of literature discussed in Chapter 2. This will be followed by the interpretation of findings as examined through my conceptual framework.

Theme 1: Responsibility of Caregiving

All participants described the activities involved in the care of their care recipient. Activities ranged from activities of daily living (ADL) and institutional activities of daily living (IADL) to transportation and financial assistance. All participants also described the experience of having to adjust to the caregiver role as an added responsibility. Some participants mentioned that they had to take over most if not all the previous responsibilities held by the care recipient. The findings from the National Alliance of Caregiving (2009) study that described the classification of caregiving activities into either ADLs or IADLs, were similar to the experiences of the participants of my study. ADLs include personal care tasks such as maintaining personal hygiene, getting in and out of chairs or beds, dressing oneself, and feeding oneself (National Alliance of Caregiving, 2009). IADLs include more complex activities such as using public transport or driving oneself around, shopping for groceries, doing housework, cooking and preparing meals, arranging for outside services, and managing finances (National Alliance of Caregiving, 2009). Additionally, these findings concur with findings from a study on caregiver burden by Kim et al. (2011). In Kim et al.'s (2011) study, a care recipient's dependence on their caregiver increased especially when the care recipient was unable to complete tasks related to ADLs or IADLs.

Although I did not examine gender in detail as a variable for this study, seven out of the eight participants are female. This concurs with a tenet in the Mediterranean model of informal care that a greater proportion of women are caregivers (del Pino-Casado et al., 2012). This conclusion may reflect some individuals' belief that it is the woman's role to be the primary caregiver in the family (del Pino-Casado et al., 2012). Accordingly, there may be a false perception that women are more involved in caregiving activities, because caregiving is considered a woman's job (del Pino-Casado et al., 2012).

Theme 2: Impact of Caregiving on Employment Status

Five participants described the impact of caregiving on their employment status. Three participants (P3, P5, and P7) were thankful they had flexible jobs where they could leave if there was an urgent matter and return later in the day. P1 decided to quit his job in order to spend time with his care recipient whereas P2 could not stop working and often felt exhausted at the end of the day. These results aligned with the APA's (2011) Resolution on Family Caregivers. Authors of the APA Resolution observed that, because family caregivers face increased burdens associated with caregiving, they may experience disruptions in their employment situation. Issues such as job dissatisfaction, absenteeism, and burnout may make balancing home and work roles difficult for caregivers (McDaniel & Allen, 2012).

Results from this study confirmed what Wang et al. (2010) concluded in a study of the effects of work status and work role inflexibility on work-life balance. Wang et al. (2010) determined that having a full-time job in addition to caregiving responsibilities contributed greatly to the role strain and caregiver burden experienced by caregivers. Most of the participants in my study stated that their caregiving experience is a difficult one because they had to balance caregiving activities and a full time job. McDaniel and Allen (2012) indicated that the interaction between family-work conflict, burnout, and psychological strain is detrimental to caregivers. This finding was confirmed in this study when several participants cited their gratitude for having flexible employment where they can take time off when needed to care for their care recipient. McDaniel and Allen (2012) also stated that family caregivers are in danger of losing or giving up their jobs because of the additional strain and responsibility of the caregiving role.

Theme 3: Impact and Importance of Religion to Caregivers

This result extends knowledge about Filipino American caregivers since I did not previously find literature about the impact and importance of religion to Filipino American caregivers. Nadal (2011) stated that Roman Catholicism was a deep and long-lasting influence on the Filipino people. However, I did not come across studies that tried to associate or link religion and its effects or influence on caregivers in general. Results from this study showed P4 and P5 considered the commandment to Honor thy father and thy mother as their motivation to care for their elderly parents. P6 on the other hand considered the commandment to “Love your neighbor” as a moral obligation. Other participants had other views regarding religion and its influence on their role as caregivers. For instance, P2 believes that a person’s values are determined by the specific religion that is practiced. P3 stated that it was her and her family’s faith that supported them through difficult times. There were also 2 discrepant cases in this study. P6 was a discrepant case because she was the only Mormon interviewed. There were also unique aspects of the Mormon faith such as the Relief Society, Compassionate service, and Gospel culture, that influenced her as a caregiver. P8 was the other discrepant case in that P8 was the only participant who stated that having a nurturing character makes you a caring person, and this is not dependent on religion.

Theme 4: Impact of Filipino Heritage on Caregivers

Each participant consistently described how important it was to them to keep close family ties as the reason and motivation for caring for their care recipient. These results confirm and relate to several studies from the review of literature in Chapter 2. Nadal (2011) described four fundamental Filipino values as well as Filipino secondary values. The four fundamental Filipino values included: *pakikisama* (social acceptance or conformity), *utang na loob* (a debt or norm of reciprocity), *hiya* (shame or loss of propriety), and *kapwa* (fellow being). P5 mentioned that “it’s probably a self-sacrifice, gratitude…” that she takes care of her parents. This directly ties into *utang na loob,* since P5 looks at her being a caregiver as a way of thanking her parents for raising her.

Nadal (2011) stated two secondary Filipino values included having the utmost respect for elders and keeping close family ties. P1 stated it was a Filipino custom to maintain close family ties. As another example, P6 stated that it was part of Filipino culture and Gospel culture to have close knit family ties. By maintaining close family ties and placing much importance on familial relationships, caregivers can rest assured that there will always be someone who will take care of the elderly family members (Varona et al., 2006). This was also confirmed by Nadal (2011) when he stated that taking care of the elderly family members is considered an honor and not at all a burden to the adult children. Additionally, the Filipino value of keeping close family ties is closely associated with familism (Nadal, 2011). Results from this study confirmed these points. P2 stated that she was taught and brought up to be caring, respectful, and considerate to family. Additionally, P2 stated that elderly relatives were encouraged to stay with their family indefinitely. P4 also stated that caring for elderly family members or relatives was important and they were not sent away. P5 stated that it was part of Filipino culture to care for elderly parents. P7 also stated that she witnessed her parents caring for her grandparents. Additionally, it was instilled in her that caring for elderly parents is part of the Filipino culture. P8 stated that the role of caregiver is automatically accepted in Filipino culture, and it is a role that is never demanded of anyone. These results also differed from the literature because of the specific points of caring for elderly parents or relatives as inherent in the Filipino culture, elderly parents or relatives are actually encouraged to stay indefinitely, and that the caregiver role is one that is accepted and not demanded.

Theme 5: Impact of Care Recipient’s Illness on the Caregiver and Recipient

Like the impact and importance of religion to the caregiver, this theme extends knowledge about the caregiving experience from the Filipino American perspective. Much of the current data focuses on caregiver burden, the caregiver role (Collins & Swartz, 2011) and depressive symptoms in both the caregiver and care recipient (McDaniel & Allen, 2012). Based on results from this study, much of the impact of the care recipient’s illness on both the caregiver and recipient, was described as difficult for both the caregiver and recipient. P1 described activities such as communication and feeding, which became more difficult over time until his care recipient was totally dependent on him and other caregivers. P1 also considered his recipient’s illness as a losing battle, which made his experience more difficult. P2, P5, and P7 did not consider their experience as difficult because their care recipients can still take care of themselves, only needing help with transportation. However, they were the only participants who noted changes in their care recipients’ personalities. P3 noted the difficulty she had staying on top of things, from the numerous doctors’ appointments to keeping track of hospital and other medical bills. P8 stated that the difficulty she experienced was tied to her care recipient’s denial of the gravity of her illness. P8’s care recipient insisted P8 and her other immediate family members not inform the children of how serious the recipient’s illness really was.

Theme 6: Resources for Caregivers

All participants mentioned resources they considered indispensable and important for them to continue caring for their care recipient fully. Most participants stated a need for financial resources. These included health insurance, social security income, and even food stamps. Specifically, P2 stated how she and her family were grateful for their care recipient's Social Security income, food stamps, and Medicare coverage as additional resources they can count on. P3 admitted that she needed more assistance with regard to understanding medical insurance and medical billing, especially after her care recipient's stroke. P4 stated that they are helped most by the additional income from her care recipient Social Security benefits. P6 and P7 also stated the importance of having medical insurance as an additional resource. Other participants stated a need for services for both their care recipient and themselves. These services included therapists, respite care, home health services, and even additional caregivers. P1 admitted that he sometimes needed additional caregivers to relieve him of caregiving duties occasionally. P4 and P7 mentioned that they are aware of respite care but they would not avail of it themselves. P6 noted the appreciation she felt when she was helped by visiting home health nurses and physical therapists for her care recipient. P7 was appreciative of the home health services her care recipient received. These insights confirmed that much like the situation in the Philippines, caregiving in the United States is also plagued with financial hardship (Varona et al., 2006).

This theme also supports the APA's stance on the importance of caregivers and caregiving through the Resolution on Family Caregivers (APA, 2011). Results from this study exhibited the importance participants placed on their contribution as the primary or only family caregiver, as well as how important their care recipient was to them. It is worth noting that whatever resources participants stated, these were the resources participants were aware of. Therefore, other possible resources that might help were not known to the caregivers.

Theme 7: Reflections on the Caregiving Experience

Results from this study validated findings that family and friends had a pivotal role in providing physical care and ensuring the emotional health of the care recipient (Epiphaniou et al., 2012). Most of the participants agreed that the caregiving role is a difficult one. P1 considered his caregiving experience as a test. Specifically, P1 stated "Caregiving is an experience that, looking back on it now, you think, 'How did I get through it?' But I'll do it again for my wife. But it's difficult, as I said". P1 considered his caregiving experience as a test of how far he would be willing to sacrifice and care for his wife, who became totally dependent on others for her activities of daily living. P2 spoke about how she also found her experience to be difficult, as well as her coping strategies. What was different from the literature about P2's account was, she was the only study participant who also tried to teach her care recipient coping methods in order for him not to be too dependent on her. P3's account also added to the literature specifically when she spoke about the balance between helping her care recipient with his activities and letting him figure things out for himself in order for him to gain his independence back. Additionally, P3's account added to the literature when she also spoke about how having a sense of gratitude helped her and her family cope with the difficulties they encountered. Furthermore, P3 also stated that having a care recipient with a positive attitude may make a difference in the stresses felt by both the caregiver and care recipient. P6 considered the caregiving experience as a part of her learning, something that will help her grow as a person. She stated she had no regrets throughout her experience, despite its difficulties. P7 stated that she thought she still can improve herself as a caregiver for her care recipient. P8 described that her life changed because of her caregiving experience, specifically because she felt that she became a grandmother and mother to her grandchildren, as her care recipient fought her illness. Additionally, most of P8's experiences as a caregiver left her disappointed because of the difficulties her care recipient experienced. She was particularly disappointed that her care recipient seemed to be in denial about her illness most of the time and had a difficult time accepting her diagnosis and prognosis. For P8, her care recipient's denial was seen in requests to keep the gravity of her situation hidden from her children as well as the care recipient's unwillingness to be open to her doctors or care providers.

Conceptual Framework and Interpretation of Findings

The results of this study verified certain aspects of the conceptual framework on which this study was based. This study was based on The Sociocultural Stress and Coping Model (SSCM), which was developed by McCallum et al. (2007). It is stated in the SSCM that ethnicity may impact aspects of caregiving, such as; (a) appraisal of caregiving as stressful based on cultural values, (b) characteristics of caregivers, (c) perceived demands of the caregiving role, (d) resulting coping styles as influenced by culture, and (e) whether the stress and coping process may result in positive or negative health outcomes (McCallum et al., 2007). Results from this study could not confirm the aspect of the appraisal of caregiving as stressful based on cultural values. This is because only P5 specifically described her experience as stressful. Additionally, P2 was the only participant who described coping methods for both herself and her care recipient. None of the participants specifically linked their perception of the stress associated with caregiving with Filipino cultural values. All the other participants (P1, P3, P4, P5, P6, P7, and P8) described their caregiving experience as difficult.

With regard to characteristics of caregivers, I asked the question, “How do you describe yourself as a caregiver?” (see Appendix B). P1 described himself as having done as much as humanly possible. P2 stated that she felt overwhelmed at times yet, she emerged from her experiences as stronger, more understanding and more patient. P3 said that she did not feel any different from being a mother. P4 stated that she felt she has not done enough. P5 described her caregiving experience as stressful and challenging. P6 stated that she did not consider caregiving as a burden; rather, it was part of her learning and growth. P7 admitted that she still had room for improvement. P8 simply described her caregiving experience as disappointing. These responses from the participants led to the emergent theme, Reflections on the caregiving experience.

Regarding perceived demands of the caregiving role, all participants described differing tasks that they considered their responsibility. P1 and P8 described taking over most if not all the responsibilities previously held by the care recipient. P2 described making sure her care recipient had everything he needed such as food and his cell phone. P3 described juggling the care of her 4 kids and her care recipient as easily overwhelming had she not been organized. P4 stated that her parents mostly depended on the financial assistance she regularly extends. P5 described that her care recipients mostly depended on her for transportation. P6 described that she mostly helped her care recipient with his medications and doctor appointments. P7 described that her care recipients were still quite independent, however they needed help with transportation and managing their health. P8 took over most if not all her care recipient’s responsibilities, including being a mother to the recipient’s young children, especially when her recipient’s health began to deteriorate. These responses led to the emergent theme, Responsibility of caregiving.

With regard to the SSCM aspect of resulting coping styles, the results of this study cannot confirm this because only P2 mentioned specific coping strategies that she and her care recipient used. Lastly, with regards to positive or negative health outcomes, this was not examined in this study. P1, P2, P3, P4, P6, P7, and P8 described their caregiving experience as difficult. P5 was the only participant to describe her experience as stressful. However, no participant described what they considered a positive or negative health outcome of their caregiving experience.

Knight and Sayegh (2010) revised the SSCM to include the idea that East Asian cultural values provide a protective effect against the viewpoint of caregiving as burdensome. Nadal (2011) noted that East Asian values emphasize mutual respect, filial piety, collectivism, and utmost respect and care for elders. This is most likely the reason why East Asian cultural values have this protective effect. Results from this study confirm the importance of utmost respect and care for elders. P1 stated that keeping close family ties was part of Filipino culture and that they were encouraged to provide care to family or relatives who needed assistance. P2 stated that it was part of Filipino culture to encourage elderly family or relatives to stay indefinitely. P4 noted that it was important to care for elderly family and relatives, and they were not sent away to live in nursing homes. P5 and P7 stated that it is part of Filipino culture to care for elderly parents. P6 reiterated that it was part of Filipino culture and Gospel culture to keep close family ties. P8 added that the caregiver role is expected in Filipino culture, and it is never demanded. All 8 participants consistently reiterated the importance of keeping close family ties as a motivation to care for and continue caring for their care recipient. The emergent theme from this study, “Impact of Filipino heritage on caregivers” verifies this aspect of the SSCM.

Empowering Caregivers: Caregiver Empowerment Model (CEM) and the COPE Model

The CEM and the COPE Models were additional conceptual frameworks for this study. The CEM and COPE Models were both developed as additional methods to increase the probability of positive outcomes from the caregiving experience. Jones et al. (2011) initially developed the CEM as a method caregivers can use to receive or elicit positive experiences from the caregiving experience. It was suggested that both positive and negative caregiving experiences be acknowledged to understand the entire caregiving experience (Jones et al., 2011). Results from this study cannot confirm participants’ positive experiences since 7 out of 8 participants described their caregiving experiences as difficult and only 1 out of 8 participants described it as stressful. None of the participants considered their caregiving experience as positive.

The theoretical background of the CEM includes the theory of meaning-focused coping (Folkman & Mosokvitz, 2000) as well as the health empowerment model (Jones & Meleis, 1993). The theory of meaning focused coping states that when caregivers find meaning in the caregiving situation, they end up meeting whatever challenge presents itself instead of simply enduring the problem until it passes (Folkman & Mosokvitz, 2000). This aspect of the CEM was not examined in this study.

The health empowerment model (Jones & Meleis, 1993) on the other hand, increases the probability that the caregiver would experience positive outcomes because additional resources from the family, community, and even the caregiver himself empowers the caregiver with the knowledge that one may look to these other resources for assistance, especially in trying situations. The results from this study coincide with the health empowerment model because of the importance all participants placed on maintaining close family ties as an additional resource. P2 was the only participant who mentioned specific strategies she employs to manage her stress, including scheduling tasks, delegating tasks to others who can help, and crying in a Church parking lot as a form of release. P4 and P7 also briefly mentioned respite care is for those who are close to burning out, and not something they would think of using for themselves. Indirectly, these results confirm the view that it is important to identify what caregivers need. Whether this need is for emotional, informational, or psychological support, identification of caregiver needs may lead to discovering effective coping strategies, support sources, and culturally appropriate and culturally sensitive interventions (Epiphaniou et al., 2012). Additionally, available resources to caregivers are increased through caregivers’ filial values as they find purpose in caring for their care recipients. For example, P1, P2, P4, P5, P6, P7, and P8 consistently stated that keeping close family ties was an essential part of Filipino culture and it was a value with which they were raised. The emergent theme that is consistent with the health empowerment model is the Impact of Filipino Heritage on Caregivers.

The COPE Model was originally intended as a teachable problem-solving skill, that included the following components: creativity, optimism, planning, and expert information (Bahrami & Farzi, 2014). Results from this study cannot confirm the effectiveness of the COPE Model. P1, P3, P4, P5, P6, P7, and P8 stated they considered their caregiving experience difficult, yet none of them mentioned whether they used coping methods to lessen their stress. This was a topic that was not covered by the interview questions. Only P2 mentioned specific methods she used to lessen her stress, as well as that of her care recipient.

Limitations of the Study

The results of this study added to the literature on Filipino American caregiver experiences, with the specific purpose of understanding and describing the impact of the caregiver role in view of Filipino cultural values. Due to the nature of this phenomenological study, it is important to describe limitations to this study. One limitation of this study is the small sample size of eight participants. The purpose of a phenomenological study is not to have transferability or generalizability of data. Therefore, a small sample is not problematic. This limitation was mitigated by ensuring saturation of data before terminating data collection. For this study, saturation was achieved after the seventh interview did not yield any new data. To satisfy confirmability, an audit trail of the research process was presented. This was achieved in this study through a detailed description of the data collection and data analysis process (Loh, 2013). Additionally, a rich and thick description of the Filipino American caregiving experience was presented through the themes that emerged from the data analysis process (Cope, 2014).

Additionally, because the inclusion criteria limited participation to Filipino American families and their caregivers, another concern was the potential for interviewer bias. Interviewer bias was a concern because there was the possibility that the guiding interview questions may be too subjective, leading, or even culturally inappropriate. This concern was resolved by presenting a draft of guiding interview questions to my dissertation chair, committee member, and especially to the Walden University Institutional Review Board (IRB) to make certain that the questions were appropriate. I only used guiding interview questions that were approved by my dissertation chair, committee member, and Walden University IRB.

Recommendations

This study was conducted to address the gap in the literature regarding the impact of the caregiving role through the unique factors of Filipino cultural values and life roles as experienced by Filipino American caregivers. The following are several recommendations for future studies. Since participation was limited to Filipino Americans and their families, future studies can examine the impact of other Filipino cultural values on the caregiving experience such as *utang na loob* or debt of reciprocity and *kapwa* or fellow being. A larger study may improve generalizability and transferability of data for future studies.

Furthermore, based on the results of this study, future studies could examine some of the specific themes found in this study to build on the existing knowledge about Filipino American caregivers. One theme that can be examined in future studies is the impact of religion on caregivers. This theme can be the basis for future studies especially when potential protective effects for the caregiver are examined. Results from this study cannot confirm whether religion had a protective effect on any of the participants because the participant responses were regarding how each participant's religion affected their caregiving experience. One example is P2, who stated that her faith enabled her to be pulled to where she was needed. P2 stated that within the Catholic faith, she was brought up to be caring, compassionate, considerate, and respectful to others, especially the elderly. Because of this background, her motivation to care for her care recipient stems from being brought up to naturally care for others. Another example was P4 and P5, who both cited the commandment to honor your father and mother as their motivation to care for their care recipient.

Another theme that can be the basis for future studies is the impact of Filipino heritage on caregivers. Results of this study showed that all the participants (8 out of 8 participants) stated that they were all taught that keeping close family ties was an important Filipino cultural value. One aspect of the revised SSCM states that culture may influence the stress and coping process of caregivers (McCallum et al., 2007). Because of this, McCallum et al. (2007) recommended that ethnic and cultural differences be examined further to determine their potential effect on the stress and coping process in caregivers.

Additional recommendations are based on the theme the impact of the care recipient’s illness on both the caregiver and care recipient. Future studies can examine additional factors that contribute to as well as alleviate caregiver burden (Knight & Sayegh, 2010). Due to the difficulty of the caregiving role, Collins and Swartz (2011) suggested measures to help the caregiver maintain their health and avoid burnout. These measures include: taking time for themselves, making sure they have adequate rest, maintaining a healthy diet, seeking preventive health care, and seeking a support group (Collins & Swartz, 2011). Results from this study did not confirm nor dispute these findings because P2 was the only participant who recounted her methods for reducing stress for both herself and her care recipient.

Implications

Implications for Positive Social Change

Collins and Swartz (2011) noted that many caregivers admit that the caregiving experience is difficult and associated with various difficulties, including psychological and physical burden, and even financial difficulties. Results of this study had implications for positive social change. Caregivers can benefit from a better understanding of the caregiving experience from the Filipino American perspective. By understanding the lived experiences of Filipino American caregivers, this knowledge can result in more accurate identification of caregiver needs. To be specific, this study had a theme of resources for caregivers, where participants stated what they considered invaluable resources to assist them in providing care for their care recipients. P2 and P4 noted the importance of receiving a monthly social security check to help with some expenses.

Another important resource was medical insurance or Medicare or Medicaid, which was mentioned by P2, P3, P6, and P7. Other important resources to the participants included having additional support such as when P1 mentioned having additional caregivers when he had to run errands and when P5 stated that she relied on her sister for occasional help.

Another theme that had implications for positive social change is the theme regarding the impact of Filipino heritage on caregivers. By taking into consideration the cultural values and background of the caregiver, culturally appropriate and culturally sensitive caregiver assessments can be made and developed (Collins & Swartz, 2011). Results from this study showed that all 8 participants considered it important to keep close family ties, as this was a cultural value that was instilled in them as they were growing up. Based on these results, culturally appropriate services such as caregiver social support and home health services can be developed, where the caregiver can take a break from caregiving without having to put the care recipient in an assisted living facility. As P2 stated, caring for elderly family or relatives is so important that they are not sent away to live in nursing homes.

Understanding caregivers’ needs based on caregivers’ cultural values may also effect positive social change by increasing understanding of the caregiver role in addition to how to prepare for it (Epiphaniou et al., 2012). Further studies on how to prepare for the caregiving role can effect positive social change because it can benefit individuals and their families such as P8, who stated that her care recipient’s illness caught the entire family by surprise. Furthermore, this knowledge and understanding can contribute to the development of appropriate social supports, coping strategies, and interventions that may decrease perceived caregiver burden (Collins & Swartz, 2011).

Methodological Implications

There have been calls for a more in-depth examination of caregivers and their experiences (David & Nadal, 2013; Kataoka-Yahiro, 2010; Kimura & Browne, 2009; Nadal, 2011; and Varona et al., 2007). I had the goal of providing a rich and thick description of the Filipino American caregiver, based on the influence of the Filipino culture and life roles that were unique to the study participants. Through this study and the use of Moustakas' (1994) modification of the van Kaam data analysis process, a more detailed description and a further understanding of the Filipino American caregiver's life experience was presented. More importantly, these descriptions come from the perspective of the caregivers themselves.

Theoretical Implications

McCallum et al. (2007) presented a revised version of the SSCM to reinterpret the effect of ethnicity on stress and coping in caregivers. Knight and Sayegh (2010) added the hypothesis that East Asian cultural values provide a protective effect against viewing caregiving as an inconvenience. The results from this study confirmed Nadal's (2011) statement that East Asian cultural values emphasize the importance of keeping close family ties, mutual support for family members and relatives, filial piety, and collectivism. The SSCM can therefore be used to develop culturally appropriate and culturally sensitive caregiver assessment, support sources, interventions, and policies for caregivers. Additionally, the SSCM can provide the theoretical basis for developing quantitative studies that can accurately assess caregiver physiological measures of health (Knight & Sayegh, 2010).

The CEM and the COPE Model provided valuable insights into additional methods to provide caregivers with additional resources the caregiver can refer to, in difficult situations. Results of this study described the difficulties Filipino American caregivers experienced as they cared for their care recipients. However, in describing the difficulties they faced, few study participants mentioned techniques they employed to reduce stress and improve coping. For example, P2 stated that time management and delegation were important strategies she employed to relieve the anxiety she occasionally experienced. Policy makers can also benefit from the implications of positive social change from this study. The CEM and COPE Model could be used as a conceptual basis in developing additional approaches with regards to caregiver assessment, caregiver needs appraisal, coping methods, policies, and interventions that may improve caregiver health. Additionally, by improving caregiver health, care recipient quality of life can improve because the caregiver can focus more on the care recipient (Jones et al., 2011).

Recommendations for Practice

Participants in this study provided valuable information regarding their life experiences as they cared for their care recipients. Emergent themes from this study included, (a) responsibility of caregiving, (b) impact of caregiving on employment status, (c) impact and importance of religion to caregivers, (d) impact of Filipino heritage on caregivers, (e) impact of care recipient’s illness on the caregiver and recipient, (f) resources for caregivers, and (g) reflections on the caregiver experience. As such, results from this study will provide family members, community members, medical and mental health professionals, and policy makers with additional information about Filipino American caregivers that may lead to an increased awareness of their needs. Furthermore, the findings of this study may provide information to health professionals and policy makers to increase awareness of caregivers' needs and from this the necessity for accurate, culturally appropriate assessments. If caregiver needs are accurately and appropriately assessed, development of effective support sources, resources, policies and interventions can alleviate caregiver burden. Descriptions of the participants' lived experiences may therefore direct future research focus based on the Filipino American perspective. Lastly, participants' descriptions of their lived experiences provided a rich and detailed background into the impact of Filipino culture and other social factors such as religion and employment on the caregiving experience.

Conclusion

The purpose of this study was to gain understanding of how Filipino cultural values and life roles affect Filipino Americans' experiences of caregiving. The goal of this study was to examine the gap in literature about the Filipino American caregiver experience that provided insights regarding the rewards, difficulties, and challenges associated with their unique experience.

There were seven emergent themes from this study; namely, (a) responsibility of caregiving, (b) impact of caregiving on employment status, (c) impact and importance of religion to caregivers, (d) impact of Filipino heritage on caregivers, (e) impact of care recipient's illness on the caregiver and recipient, (f) resources for caregivers, and (g) reflections on the caregiver experience. Participants' descriptions of their life experiences coincided with the SSCM in that the importance Filipino American caregivers place on family relationships may provide a protective effect against viewing caregiving as burdensome. All eight participants consistently stated that it was instilled in them, to realize the importance of caring for elderly family or relatives. P2 and P4 stated that caring for elderly family and relatives is a cultural value and thus part of being Filipino, such that the use of nursing facilities is discouraged. Additionally, the impact of Filipino heritage on caregivers, confirmed one aspect of the CEM, where the probability that the caregiver experienced positive outcomes in caregiving is increased (Jones & Meleis, 1993). This is because by keeping close family ties, the caregiver receives additional resources from the family and the community. This in turn empowers the caregiver with the knowledge that they can look to these additional resources for assistance (Jones & Meleis, 1993).

The information that was collected from the 8 participants as they described the impact caregiving had on their life experiences helped me achieve my study's purpose. It was especially important that they described these experiences from their perspectives. Participants provided a rich and detailed description of the Filipino American caregiving experience, emphasizing the importance of keeping close family ties as motivation for assuming the responsibility of caregiving. Additionally, participants considered family as an important resource they could depend on for additional assistance with caregiving. Another important result of this study were the descriptions of the difficulties faced by participants as they continued their caregiving responsibilities. From this information, it is hoped that a better understanding of the Filipino American caregiving experience will be achieved. It is also hoped that the knowledge gathered from this study may lead to the development of culturally sensitive and culturally appropriate needs assessment, services, and interventions for the Filipino American caregiver.

References

American Psychological Association. (2011). Resolution on family caregivers. Retrieved from http://www.apa.org/about/policy/family-caregivers.aspx

Bahrami, M., & Farzi, S. (2014). The effect of a supportive educational program based on COPE model on caring burden and quality of life in family caregivers of women with breast cancer. *Iranian Journal of Nursing & Midwifery Research*, *19*(2), 119-126. Retrieved from http://www.ijnmr.mui.ac.ir/

Bainbridge, H. J., Cregan, C., & Kulik, C. T. (2006). The effect of multiple roles on caregiver stress outcomes. *Journal of Applied Psychology*, *91*(2), 490-497. doi:10.1037/0021-9010.91.2.490

Barbosa, A., Figueiredo, D., Sousa, L., & Demain, S. (2011). Coping with the caregiving role: Differences between primary and secondary caregivers of dependent elderly people. *Aging & Mental Health*, *15*(4), 490-499. doi:10.1080/13607863.2010.543660

Collins, L., & Swartz, K. (2011). Caregiver care. *American Family Physician*, *83*(11), 1309-1317. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21661713

Commonwealth Fund. (2005). *A look at working-age caregivers' roles, health concerns, and need for support* (Issue Brief No. 854). Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2005/aug/a-look-at-working-age-caregivers-roles--health-concerns--and-need-for-support

Converse, M. (2012). Philosophy of phenomenology: How understanding aids research. *Nurse Researcher, 20*(1), 28-32. doi:10.7748/nr2012.09.20.1.28.c9305

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91. doi:10.1188/14.ONF.89-91

Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*, *54*(2), 88-94. doi:10.1111/j.1440-1630.2007.00661.x

David, E. R., & Nadal, K. L. (2013). The colonial context of Filipino American immigrants' psychological experiences. *Cultural Diversity and Ethnic Minority Psychology, 19*(3), 298-309. doi:10.1037/a0032903

del-Pino-Casado, R., Frías-Osuna, A., Palomino-Moral, P. A., & Ramón Martínez-Riera, J. (2012). Gender differences regarding informal caregivers of older people. *Journal of Nursing Scholarship*, *44*(4), 349-357. doi:10.1111/j.1547-5069.2012.01477.x

Epiphaniou, E., Hamilton, D., Bridger, S., Robinson, V., Rob, G., Beynon, T., & ...Harding, R. (2012). Adjusting to the caregiving role: The importance of coping and support. *International Journal of Palliative Nursing*, *18*(11), 541-545. doi:10.12968/ijpn.2012.18.11.541

Goldberg, A., & Rickler, K. (2011). The role of family caregivers for people with chronic illness. *Medicine & Health Rhode Island, 94*(2), 41-42. Retrieved from https://www.rimed.org/2011-02.asp

Hamill, C., & Sinclair, H. (2010). Bracketing - practical considerations in Husserlian phenomenological research. *Nurse Researcher*, *17*(2), 16-24. doi:10.7748/nr2010.01.17.2.16.c7458

Hong, L. (2004). Barriers to and unmet needs for supportive services: Experiences of Asian-American caregivers. *Journal of Cross-Cultural Gerontology*, *19*(3), 241-260. doi:10.1023/B:JCCG.0000034221.07028.9a

Jones, P. S., Winslow, B. W., Lee, J. W., Burns, M., & Zhang, X. E. (2011). Development of a caregiver empowerment model to promote positive outcomes. *Journal of family nursing*, *17*(1), 11-28. doi:10.1177/1074840710394854

Kataoka-Yahiro, M. R. (2010). Filipino American grandparent caregivers’ roles, acculturation, and perceived health status. *Journal of Cultural Diversity*, *17*(1), 24-33. Retrieved from http://tuckerpub.com/jcd.htm

Kimura, J., and Browne, C. V. (2009). Eldercare in a Filipino community: Older women's attitudes toward caregiving and service use. *Journal of Women & Aging*, *21*(3), 229-243. doi:10.1080/08952840903054815

Knight, B. G., & Sayegh, P. (2010). Cultural values and caregiving: The updated Sociocultural stress and coping model. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences*, *65B*(1), 5-13. doi:10.1093/geronb/gbp096

Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *Qualitative Report*, *18*(33), 1-15. Retrieved from http://nsuworks.nova.edu/tqr

Losada, A., Marquez-Gonzalez, M., Knight, B. G., Yanguas, J., Sayegh, P., & Romero-Moreno, R. (2010). Psychosocial factors and caregivers' distress: Effects of familism and dysfunctional thoughts. *Aging & Mental Health*, *14*(2), 193-202. doi:10.1080/13607860903167838

McCallum, T., Longmire, C., & Knight, B. (2007). African American and White female caregivers and the Sociocultural stress and coping model. *Clinical Gerontologist*, *30*(4), 25-37. doi:10.1300/J018v30n04_02

McDaniel, K. R, & Allen, D. G. (2012). Working and caregiving: The Impact on caregiver stress, family-work conflict, & burnout. *Journal of Life Care Planning*, 10(4), 21-32. Retrieved from https://www.rehabpro.org/publications/jcp-indexMoustakas, C. (1994). Phenomenological research methods. SAGE Publications, Inc. doi: 10.4135/9781412995658

Moustakas, C. (1994). 1 Human science perspectives and models. In *Phenomenological research methods.* (pp. 1-25). SAGE Publications, Inc. doi:10.4135/9781412995658.d3

Moustakas, C. (1994). 2 Transcendental Phenomenology: Conceptual framework. In *Phenomenological research methods.* (pp. 25-43). SAGE Publications, Inc. doi: 10.4135/9781412995658.d4

Moustakas, C. (1994). 3 Phenomenology and human science inquiry. In *Phenomenological research methods.* (pp. 43-68). SAGE Publications, Inc. doi: 10.4135/9781412995658.d5

Moustakas, C. (1994). 4 Intentionality, noema, and noesis. In *Phenomenological research methods.* (pp. 68-84). SAGE Publications, Inc. doi: 10.4135/9781412995658.d6

Moustakas, C. (1994). 5 Epoche, phenomenological reduction, imaginative variation, and synthesis. In *Phenomenological research methods.* (pp. 84-103). SAGE Publications, Inc. doi: 10.4135/9781412995658.d7

Moustakas, C. (1994). 6 Methods and procedures for conducting human science research. In *Phenomenological research methods.* (pp. 103-120). SAGE Publications, Inc. doi: 10.4135/9781412995658.d8

Moustakas, C. (1994). 7 Phenomenological research: Analyses and examples. In *Phenomenological research methods.* (pp. 120-155). SAGE Publications, Inc. doi:10.4135/9781412995658.d9

Moustakas, C. (1994). 8 Summary, implications, and outcomes: A Phenomenological Analysis. In *Phenomenological research methods.* (pp. 155-177). SAGE Publications, Inc. doi:10.4135/9781412995658.d10

Nadal, K. L. (2011). Filipino American Psychology: A handbook of theory, research, and clinical practice. John Wiley and Sons, Inc.: Hoboken, New Jersey.

National Alliance for Caregiving (2009). *Caregiving in the U.S.* Retrieved March 1, 2013, from http://www.caregiving.org

Nicholls, D. (2009). Qualitative research: Part three-Methods. *International Journal of Therapy & Rehabilitation*, *16*(12), 638-647. doi:10.12968/ijtr.2009.16.12.45433

Pratama, A. P. & Firman, A. F. (2010). Exploring the use of Qualitative Research Methodology in conducting research in cross cultural management. *International Journal of Interdisciplinary Social Sciences*, *5*(2), 331-342. Retrieved from http://iji.cgpublisher.com

Scheidegger, G., Lovelock, L., & Kinébanian, A. (2010). The daily lives and occupations of Tibetan families who have a child with disabilities. *Scandinavian Journal of Occupational Therapy*, *17*(4), 286-298. doi:10.3109/11038120903287174

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, (2), 63. doi:10.3316/QRJ1102063

VandenBos, G. R. (Ed.). (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.

Varona, R., Saito, T., Takahashi, M., & Kai, I. (2007). Caregiving in the Philippines: A quantitative survey on adult-child caregivers' perceptions of burden, stressors, and social support. *Archives of Gerontology and Geriatrics*, *45*(1), 27-41. doi:10.1016/j.archger.2006.07.007

Yu-Nu, W., Yea-Ing Lotus, S., Min-Chi, C., & Pei-Shan, Y. (2011). Reconciling work and family caregiving among adult-child family caregivers of older people with Dementia: Effects on role strain and depressive symptoms. *Journal of Advanced Nursing*, *67*(4), 829-840. doi:10.1111/j.1365-2648.2010.05505.x

Appendix A: Invitation Flyer

Invitation Flyer

Would you like to tell your story about your experiences as a caregiver?

You May Be Eligible For This Study If:

- Speak and read fluent English;
- At least 18 years of age;
- Providing constant care for either a spouse, or other immediate family member or relative for at least a year and for which no payment is received;

The purpose of this study is to understand and describe the impact of the caregiving role as it is experienced by Filipino American caregivers. The study will focus primarily on your personal experiences as a family caregiver, your difficulties, the resources and strategies you rely on to help you fulfill your role as a family caregiver. By sharing your story, the results of this study have the potential to impact the development of programs and services that would be beneficial to other Filipino American family caregivers like yourself.

What You Will Be Asked To Do:

Should you agree to participate in this study, you will be asked to take part in an audiotaped, interactive interview that would last for about 60 minutes. The interview will be conducted at a time and location convenient for you. A secondary follow up communication may be necessary in order to clarify some interview answers, and may take place by phone call. All information will be confidential and used solely for the purpose of understanding the experiences of Filipino American caregivers.

This research project is part of a dissertation study conducted by Maribel Dominguez, a Walden University doctoral candidate.

If you are interested, please contact Maribel Dominguez either by phone or email.

Appendix B: Guiding Interview Questions

1. Are you the sole caregiver for the care recipient? If not, please describe the other individuals who help you care for your loved one.
2. Are you the sole breadwinner for the care recipient? If not, please describe the other individuals who help you care for your loved one.
3. Is being the caregiver your sole role in the family? What are your other roles/responsibilities?
4. What is your reason or reasons for becoming the family caregiver?
5. How important is this role for you? How important are your other roles?
6. When was the care recipient diagnosed with their condition/illness?
7. Where were you raised? In the Philippines or in the United States?
8. What is your religion? Do you actively practice it?
9. Do you feel that your religion influences your decisions and experiences as a caregiver? Please elaborate on your experiences.
10. Do you feel there are cultural values as a Filipino that contribute to being a caregiver for your family member or relative?
11. To what extent do you consider your decisions and experiences in the caregiver role influenced by how and where you were raised? Please elaborate on your experiences.
12. Please tell me about your other experiences as a caregiver for your loved one.
13. How would you describe yourself as a caregiver for your loved one?

14. Do you consider your life has changed since you started caring for the care recipient? If so, please tell me how your life has changed since you took on the responsibility of caring for the care recipient.
15. Please tell me how you care for the care recipient on a daily basis.
16. Have you had difficult experiences in caring for your loved one? If so, please describe them.
17. Do you have strategies to deal with these difficulties? If so, please describe them.
18. Do you have other resources that you consider beneficial to your role as caregiver? Please describe them?
19. Are there other resources that you think you need? Please describe them.
20. Is there anything else that you would like to tell me that will help me further understand your experience as a family caregiver?

Appendix C: Letter of Cooperation from Community Research Partner

xxxxxxxxxx
xxxxxxxxx
xxxxxxx

14 Jan. 2016

Dear Maribel Dominguez,

Based on my review of your research proposal, I give permission for you to conduct the study entitled, “Filipino American caregivers’ perspectives on the Caregiver Role” with participants from xxxxxxxx. As part of this study, I hereby authorize you to speak at one of our group meetings to describe your study and leave your flyers and contact information. I also authorize you to collect your study data through in-depth interviews with volunteer participants from our xxxxx Group. Individuals’ participation will be voluntary and at their own discretion. Interviews will be conducted at a mutually agreed upon location that provides privacy, or if distance becomes an issue, interviews by phone or skype are permissible. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB.

Sincerely,

xxxxxxxxxxxxxxxxxxx
xxxxxxxxx
[redacted]

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person’s typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix D: No- or Low-Cost Psychotherapy Resources in the Greater Houston Area

I retrieved the following information from the website of Mental Health America of Greater Houston (www.mhahouston.org).

- Peer Support: free

  Depression and Bipolar Support Alliance (multiple locations)
    713.600.1131
    www.dbsahouston.org

- Counseling: sliding fee scale for services

  Houston Galveston Institute (By appointment or Walk-In Clinic on Saturdays with no appointment)
    713.526.8390
    3316 Mount Vernon St. 77006

  Family Services of Greater Houston (multiple locations)
    713.861.4849 - call for appointment

- Comprehensive Mental Health Care: will require an eligibility process, fee is income based

  Federally Qualified Health Centers (FQHCs) or other low cost clinics

  Gateway to Care Navigators: dial 713-783-4146 to find the closest FQHC

  Harris Health Behavioral Health Program (multiple locations)
    Eligibility: 713-566-6509
    Appointments: 713-526-4243
    www.harrishealth.org

  Legacy Community Health Services (multiple locations)
    832.548.5000
    www.legacycommunityhealth.org

  MHMRA (multiple locations)
    713-970-7070
    Eligibility: 713.970.4444

- In the event of a psychiatric emergency:

  Dial 911 and request a Crisis Intervention Team or CIT Officer

  Go to MHMRA Neuropsychiatric Center (NPC) — 24 hour emergency psychiatric facility
  1502 Taub Loop Houston TX 77030
  713.970.7070

Appendix E: Emerging themes and Invariant Constituents

Emerging themes	Invariant constituents
Responsibility of caregiving	a. ADLs and taking over wife's role (P1) b. Making sure all needs are met and prepared (P2) c. Taking care of the care recipient and the children, taking care of his medical needs (P3) d. Transportation and meal preparation (P4) e. Transportation and companionship (P5) f. Supervision of medications (P6) g. Having a full-time job, caring for care recipient and making sure medical needs are met (P7) h. Hygiene, meals, running the household (P8)
Impact of caregiving on employment status	a. Quitting a job to be with her (P1) b. Having nothing left for yourself (P2) c. Accommodations for both caregiver and care recipient at place of employment (P3) d. Taking time off work to accompany parents to the Philippines (P5) e. Job is flexible enough to allow participant to leave and go check on parent (P7)

(*table continues*)

Emerging themes	Invariant constituents
Impact and importance of religion to caregivers	a. Worked with the church to provide accommodations for wheelchair-bound wife (P1) b. Faith directs you to where you should be (P2) c. Relying heavily on faith, prayers, and hope (P3) d. Follow the commandment to respect and honor your parents (P4) e. Honor your father and your mother (P5) f. Being a member of the Church of Jesus Christ and Latter-Day Saints, it is a moral obligation to help others (P6) g. It doesn't matter what religion you belong to or practice, as long as you have a nurturing character (P8)
Impact of Filipino heritage on caregivers	a. Custom of Filipinos to be close to and help relatives, taking care of the sick is a cultural value in the Philippines, being in the Philippines is easier because there are more people you can depend on (P1) b. Brought up to be caring, considerate, respectful and loving, old people grow old and die with family members, life in the Philippines is different because you have help (P2) c. Part of the culture to care for the parents in their old age (P4) d. Witnessed older relatives care for the elderly, patience is a reason why the elderly are not sent away (P5) e. Filipinos are family oriented (P6) f. It's part of the culture to care for the elderly (P7) g. Parents still have a role in their adult children's lives, older sisters tool care of elderly relatives (P8)

(*table continues*)

Emerging themes	Invariant constituents
Impact of care recipient’s illness on caregiver and recipient	a. Communication, feeding became difficult as time passed, however, she did not give up. She lasted 12 years (P1) b. Travel is difficult because he has to be in a wheelchair. His attitude changed, he is more needy and impatient (P2) c. Despite the possibility he may not walk again, he proved everyone wrong and is walking by himself with a cane (P3) d. Depending on others to provide transportation, sometimes they are very needy, and they have a difficult time adjusting (P5) e. We have to adjust especially when we travel, she slows us down (P7) f. She was in denial about the extent of her illness so I had to prepare myself (P8)
Resources for caregivers	a. Additional caregivers, Medicare, hospice care (P1) b. SSI, food stamps, insurance, Medicare (P2) c. Insurance and medical billing (P3) d. Social security and respite care (P4) e. Family members help out (P5) f. Home health, Physical therapist, insurance (P6) g. Wound care center, home health, respite care (P7) h. Help with nursing tasks, family helping out with expenses (P8

(*table continues*))

Emerging themes	Invariant constituents
Reflections on the caregiving experience	a. Did as much as humanly possible (P1) b. Despite the hardship, just think you are doing it for a loved one (P2) c. Being grateful and having a positive state of mind helps (P3) d. It's stressful but worth it (P5) e. It isn't a burden because it's part of your learning and growth as a person (P6) f. It isn't easy (P7) g. Caregiver's life changed but mostly because of disappointments during care recipient's illness (P8)