



Abstract: Research has shown that ethnic variations in caregiving exist. However, less attention has been given to the common experience of caregiving, across ethnic group affiliation. Semi-structured interviews with African American, Caucasian American, and Latino caregivers were conducted to understand the common experience of caregiving. Four major themes that characterized the caregiving experience across the three ethnic groups were identified. Participants described a tradition of family care, prevalent across the three ethnic groups. Familial conflicts, caregiving dissonance, and low levels of use of formal services also were prominent characteristics of the caregiving experience across the three ethnic groups. Results support the existence of a culture of caregiving prevalent across ethnic group affiliation.

Key words: Cultural Variants, Caregiving, Culture of Caregiving

CULTURAL VARIANTS OF CAREGIVING OR THE CULTURE OF CAREGIVING

Culture is defined as shared values, norms, beliefs, and practices that guide the thinking, behaviors, and decisions of the group (Pickett, 1993). Race and ethnicity are often considered interchangeably as variables by which culture is identified. However, culture is a complex multifaceted construct, identified by the interaction between numerous sociodemographic variables. Furthermore, culture is not an unchangeable construct, but instead, it is constantly recreated within its historical and social context.

Four major theories have attempted to explain the role of race/ethnicity in the caregiving experience: (a) theories of *cultural pluralism* emphasize the notion of ethnic group differences that persist in the presence of the majority culture (Markides & Mindel, 1987); (b) the *assimilation perspective* suggests a gradual shift from traditional values and behaviors characteristic of the ethnic group towards values held by the majority group (Park, 1950); (c) the *double jeopardy theory* emphasizes the dual disadvantage posed by both age and race on ethnic minority caregivers (Jackson, 1971); (d) the *ethnic compensation theory* emphasizes the strengths and benefits associated with being a member of an ethnic minority group.

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RACE/ETHNICITY AS EXPLANATORY VARIABLES

Most cross-cultural research holds the assumption that race/ethnicity represent important grouping variables. The tendency of contemporary research to focus on the rejection of the null hypothesis as a major research goal has increased awareness of racial/ethnic group differences. Less attention, however, has been given to similarities in the caregiving experience across racial/ethnic group affiliation.

In the United States, approximately 80% of the care for older adults is provided informally, oftentimes, by a single family-member (Matthews & Rosner, 1988). It is argued that caregiving is more prevalent among ethnic minorities than among Caucasian American families, ranging from 29% for African American and 27% for Latino compared to 24% for Caucasian American families (National Alliance for Caregiving and the American Association for Retired Persons, 1997).

A review of the literature suggested that the caregiving role is most likely to be fulfilled by a female (Ayalon & Huyck, in press). Furthermore, the designated caregiver often faces the caregiving task alone and does not receive adequate informal support (Hinrichsen & Ramirez, 1992; Levkoff, Levy, & Flynn Weitzman, 1999). However, the relationship of the caregiver to the care recipient varies across ethnic group affiliation. Latino caregivers are most likely to be daughters or daughters in-law (Cox & Monk, 1993; Harwood et al., 2000), Caucasian Americans are

most likely to be spouses (Connell & Gibson, 1997), while African American caregivers are most likely to be adult children, friends, or members of the extended family (Connell & Gibson, 1997).

Underutilization of formal services is pervasive among Caucasian American, African American, and Latino caregivers (Cox, 1999; Haley et al., 1996; Hinton & Levkoff, 1999). However, most research suggests that relative to Caucasian Americans, ethnic minorities underutilize mental health services. Wood and Parham (1990) found that Caucasian American caregivers attended support groups more frequently than African Americans. In addition, relative to Caucasians Americans, older African Americans are less likely to use nursing home services (Miller, McFall, & Campbell, 1994). Similarly, research suggests low levels of formal service utilization among Latino caregivers, relative to Caucasian American caregivers (Hinton & Levkoff, 1999; Henderson, Gutierrez-Mayka, Garcia, & Boyd, 1993).

Caucasian American, African American, and Latino caregivers, all report an increase in physical symptoms over time (Cox & Monk, 1996; Roth, Haley, Owen, Clay, & Goode, 2001). However, ethnic group differences in the report of depressive symptomatology and other negative aspects of caregiving have been noted. A review of the literature, conducted by Ayalon and Huyck (in press) revealed higher levels of depression and stress among Latino caregivers relative to other ethnic groups. In addition, relative to African Americans, Caucasian American caregivers reported higher levels of depression and role strain, and a decrease in life satisfaction over time (Dilworth-Anderson & Anderson, 1994; Roth et al., 2001). In contrast, African American caregivers reported greater satisfaction with caregiving than Caucasian American caregivers and were more likely to report that caregiving is an expected experience (Haley et al., 1996; Lawton, Rajagopal, Brody, & Kleban, 1992; Picot, Debanne, Namazie, & Wykle, 1997).

THE PRESENT STUDY

To date, the majority of research has focused on racial/ethnic group differences, with little attention given to commonalities in the caregiving experience. The present study, in contrast, focused on characteristics that are common to caregivers of three ethnic groups: Latino, African American, and Caucasian American. By focusing on commonality across different ethnic groups, the present study is likely to provide further support for the view of caregiving as a cultural system. We hypothesized that caregivers across all three ethnic groups share similar values, attitudes, and experiences related to informal care and, therefore, can be defined as members of a unique cultural group of caregivers.

METHOD

Participants and Procedure

Participants were recruited through the SeniorCare project; a program administered by Metropolitan Family Services and funded by the Administration on Aging for two and a half years. The program operates in several blue-color communities in the vicinity of Chicago. Participants who agreed to participate in the study received an explanation about the purpose of the study and signed a consent form. The sample consisted of three Latino, two African American, and three Caucasian American caregivers. Participants were recruited from a convenient sample, but were selected in order to reach maximum variations. The maximum variation sampling allows studying both unique variations and common patterns that cut across the variations (Patton, 1990). Sampling targeted both male and female caregivers of diverse ethnic groups.

A semi-structured interview was administered. Participants were asked about use of and expectations from formal and informal services. Participants were also asked about the role of culture in shaping their Caregiving experience and about the role of the family in the Caregiving experience. Other questions included caregivers' perception of the Caregiving experience and the perception of the care recipient's condition. All interviews were conducted in English and lasted between 1 to 1.5 hours. Each interview was analyzed thematically. Themes were categorized and then re-categorized in order to identify common themes across the 3 ethnic groups.

RESULTS

Characteristics of the Sample

Seven of the eight participants were female. Three participants were Latino (2 born in Latin America and one born in the United States; 2 of the Latina participants were sisters), 3 participants were Euro American (2 born in Europe and one born in the United States), 2 participants were African American born in the United States.

Five of the 8 caregivers provided care to multiple family members; all three Latina participants provided care to both a sibling and a parent. A Euro American participant provided care to her special-need children and her husband. An African American participant provided care to her mother, her husband, her special-need child, and her niece and nephew. Three participants provided care to a single family-member; an African American participant and a Euro American participant provided care to a mother. Another Euro American participant provided care to a spouse. Five of the participants provided care primarily to a cognitively impaired care recipient. The other 3 participants provided care primarily to a medically impaired care recipient.

Content Analysis

Data analysis was in the form of content analysis and identified the following themes: 1) caregiver dissonance; 2) role of culture; 3) familial conflict and 4) use of formal services.

The Caregiver's Dissonance. The process of adjusting to the contradictions associated with the caregiving experience was a major theme expressed by most caregivers. As stated most directly by an African American caregiver: "I am glad that I can take care of her (care recipient), sometimes happy that I take care of her, most of the time I am sad to see my mother deteriorating, sometime overwhelmed, always feel guilty, never think I do enough".

Most people interviewed reported being stressed and overwhelmed. However, they continued caring for their loved ones. In addition to the negative feelings associated with caregiving, caregiving has provided several caregivers with feelings of mastery, control, and uniqueness. As stated by a Euro American caregiver: "I feel good. Sometimes it is overwhelming, but I will never regret it. Sometimes I would like to have some time away... I am running under pressure..."

Not only emotional dissonance was reported, but also a cognitive dissonance. A Latina caregiver stated: "never knew how difficult it (caregiving) would be. It is the right thing to do, though. Feels right to me..." Another Latina caregiver stated: "I love my parents. It is my responsibility. It is always frustrating when it (caregiving) becomes a priority..."

An African American caregiver identified a continuum of care to describe her adjustment to caregiving. Care was described as a mutual reciprocal activity, while caregiving was described as no longer mutual or reciprocal, but "what you do out of love". Care taking, in contrast, was described as "doing things you have to do". The caregiver described her 'journey' along the continuum of care, stating that she initially thought of herself as a caretaker, "...someone who watches over like a guardian...it felt like you are not giving to the person. You just do it because you have to". She then resolved the dissonance by thinking of herself as a caregiver, "caregiving is more positive. You give because you want to".

Dissonance between cognitions and behaviors also was reported. An African American caregiver, when providing an etiological explanation for her mother's illness stated, "Mom cared for 10 children and grandchildren... too many people. Not paying attention for her own medical signal". When explaining her son's illness, she stated: "Son is not getting enough attention because I am so involved in caregiving". The same caregiver, despite her view of the illness as resulting from inadequate self-care or inadequate care from others and despite her description of her caregiving experience as "hell" continued to provide care to multiple family members.

At times, the dissonance was reported, but not fully acknowledged by the caregiver. One of the caregivers stated that she did not define herself as a caregiver, despite caring for multiple family members: "I never thought of my self as a caregiver. I care for 4 people. This is my family. I care for every body. Never thought of this as something I have to do. This is the right thing to do".

The Role of Culture. All but one caregiver argued that their culture emphasizes the value of 'taking care of your own'. This notion was expressed, regardless of ethnic origin. However, ethnic origin was often offered as the major reason for this tradition of family care. A Latina caregiver stated, "I couldn't turn away. Part of the culture is you take care of your parents. In the *Mexican* culture, you never think of a nursing home". Another Latina caregiver stated, "Some European cultures have the experience of taking care of your own... (However), *Anglo* culture is more liberal, more detached from their own family members. They have the ability to put parent in a nursing home. This would be my last resort". Similarly, a Euro American caregiver stated, "In *Europe*, some one always used to live with old people. They didn't live alone". An African American caregiver stated, "My family feels that the family should take care of the elderly. This is the *African American* community. This is their pride".

Six of the 8 caregivers interviewed noted that their culture is not only defined by ethnic identity, but is also a product of the specific cohort and the cultural values prevalent in the United States. The majority of caregivers expressed their disappointment with the younger generation, which does not follow their culture of caregiving. An African American caregiver described a de-culturation process of her family: "it was a tradition that the family would take care of the older parent at home...things have changed. Now people expect me to do every thing. I try to talk with the younger people in the family to assist with caregiving, but this doesn't work...with my family, there is not enough verbal communication between us. In my family every one is living for themselves... I thought I was a role model for them. Now there is a division between us". Similarly, a Euro American caregiver stated: "I grew up with the idea that parents take care of children and children then take care of parents. In this country people spread out...The newer generation is spread out. It is not because we didn't teach our kids. Every thing is different now". The role of level of acculturation was implicitly offered as an important factor in the caregiving experience: "it took my siblings a long time to realize we should send him (care recipient) to a nursing home. I realized first (youngest sibling, born in the U.S.). My oldest sisters (born in Mexico) were the last to agree".

Others, reflecting on their own caregiving experience, expressed fears regarding the availability or will of the new generation to care for them in the future: "they (family) cared for me. Now is the time for me to care for them. The biggest question is who is going to care for me when I get older". Another caregiver stated: "if something happens to me, they will take him in or put him away? They will probably put him in a nursing home or get some one to come to the house".

Caregivers spoke of a lifelong exposure to caregiving either through observation of their parents caring for other family members or through direct involvement in family care from an early age. A Latina caregiver stated: "when I was growing up both of my grandmothers on both sides and two of my aunts, one on each side, were taken care of by my mother until they passed away. My mother even brought the mother of my step older brother from the hospital and took care of her. My values are that you can not abandon old members". A Euro American caregiver stated: "my brother moved in with my parents and took care of them for 5 year". A Latina caregiver spoke about her lifelong experience of providing care: "my parents don't speak English. (They) always needed my assistance..." Similarly, a Euro American caregiver stated: "I took care of every one...every one was sick in my family." An African American caregiver stated: "first time I thought of my self as a caregiver was 30 years ago when I cared for my grandfather..."

Familial Conflict. Four of the caregivers interviewed (1 Latina, 2 Euro American, and 1 African American) identified themselves as the primary caregivers and claimed to receive almost no help from other family members. The other four caregivers shared the care with their siblings.

Three of the caregivers who shared the care with their siblings argued that together they are able to provide better care to their loved ones. One of the Latina sisters stated: "You feel like you are part of a little machine. The family is the priority". The other sister stated: "it unites us (siblings) more when we have a problem. We break down responsibilities. We all have specialties". A Euro American caregiver stated that what distinguishes him from other caregivers is the help he receives from his brother: "many caregivers do not have another person to help them. It is a good idea to have someone for lifting or for exchange of ideas..."

Despite individual differences in the level of familial share, all, but one caregiver, reported some sort of familial conflict related to the caregiving experience. Conflicts concerning privacy versus share of the care were described by several caregivers. An African American caregiver stated: "my family believes it is the family that takes care of the elderly...they

believe it stays in the family... I don't conform with the way they see things...I believe in villages (extended network of care that includes formal services) ... The whole village takes care of the older adult". A Latina caregiver also stated: "I tried to convince sisters (to place care recipient in a nursing home) by expressing my concerns. I never quit (caregiving), although I threatened to".

Others described familial conflicts concerning the distribution of work within the family system. A Euro American caregiver stated: "now you always have to ask for help from your sons. Help is not there. You have to bend down and ask. This is not me. I am a very independent person". Another Euro American reported similar experiences: "family helps when I ask them. I don't want to ask for help from them. My family is always asking, but I don't tell them how bad he is". Similarly, a Latina caregiver reported: "when time comes...I tell brother I will call him. But for now, I get along well".

Only one Latino caregiver reported having conflicts with the care recipient: "I have to understand she (care recipient) is sick. She snaps sometimes as part of the medications. I also have to understand she wants to be cremated. After talking with the social worker and my spiritual adviser, I decided to accept her wishes". This caregiver was the only one to mention spirituality and religious involvement as helpful tools in dealing with familial conflicts

Ways of resolving the familial conflict varied from logical persuasion to passive acceptance and even justification of the other party. The majority of the caregivers interviewed chose a more passive path for conflict resolution. As stated by an African American caregiver: "the fact that I try to help my family even though I want to strangle them shows that I still have a sense of family. I do not fight with my sister and her husband. I keep my thoughts to my self. The only reason I talk to them is the sense of family. If they were strangers, I wouldn't be talking to them".

Justifying the lack of familial involvement of other family members also was common. A Latina caregiver to account for the fact that her extended family is not involved in her father's care, stated: "they (extended family) associate illness with weakness. They try to hide illness. They are afraid. They are at the same age, asking themselves what will happen to me?". Another Latina caregiver responded: "it is not easy for any one in my family to be here. My daughter and son are extremely sensitive. It is hard for them... they cry seeing how much she (care recipient) has deteriorated. My brother is concerned, but he has his family and work over there..." Similarly, an African American caregiver, discussing lack of involvement of the younger generation in her family, stated,... "maybe they are afraid to be next to older

adults". A Euro American caregiver stated: "my brother helps out occasionally. He is in the suburbs and has his own family to care for..."

Formal Service Use. All caregivers interviewed in the present study used support services, such as respite care or support groups, provided by Metropolitan Family Services. However, they used little or no formal services to directly assist in the care of the care recipient. One African American caregiver used a homemaker, two Latina caregivers (sisters) placed their father in a nursing home, and a Euro American caregiver used very seldom day care services. The other caregivers used no additional formal services to assist with the care of their loved ones. Furthermore, only two caregivers thought that formal services should be more involved in the care of their loved ones.

Several reasons for low levels of use of formal services were offered. Among the reasons were financial explanations: "I wish they had some kind of help that would come in-home for several hours. Paid services that would come and help. If they don't help you financially, I can't afford this", lack of visibility of formal services, "some programs need to be more visible... for some reason resources are not available... The social worker did not know more than me, by the time we got there", lack of cultural sensitive services, "(unlike previous experiences with formal services) he (social worker) understood the culture and knew what we were working with", dissatisfaction with the quality of care, "I don't feel it is the greatest. Not always clean...", the wish to keep the care recipient in his or her natural environment, "it is really sad. We pulled dad from us and from the environment he used to see every day", and the view of the care as a personal or a familial responsibility, "now that her legs are not working, you can't hire someone to do some thing like that".

DISCUSSION

The present study analyzed semi-structured interviews of eight caregivers of three different ethnic groups in order to better understand the commonalities across ethnic group affiliation. The study identified four major themes that characterize the caregiving experience across the three ethnic groups. These themes can be considered as representing a collective experience of caregiving. Unlike previous cross-cultural research that focused primarily on racial or ethnic group differences in the caregiving experience, the present study views caregiving as a major cultural system and suggests that race and ethnicity, though important cultural classifications, do not diminish commonalities in the caregiving experience.

The Caregiver's Dissonance. Dissonance was identified as a common experience of the caregivers

in the present study. The subjective experience of caregivers is complex; oftentimes, care is provided despite emotional, financial, and social costs. Most research attempts to quantify the negative aspects of caregiving by evaluating levels of depression, burden, stress, or other negative consequences associated with caregiving. When positive aspects of caregiving are evaluated, this is often done separately from the evaluation of the negative aspects. The present study, in contrast, suggests that negative and positive aspects of caregiving cannot and should not be separated. The caregivers in our study reported simultaneous experience of, sometimes, contradictory emotions and thoughts. Similarly, Lawton et al. (1992) found that both African American and Caucasian American caregivers who provided care showed simultaneously more satisfaction and more burden. A more accurate understanding of the caregiving experience will be gained by simultaneously evaluating the contradicting emotions and thoughts experienced by the caregivers. More clinical attention should be directed into helping caregivers accept and resolve their contradictory experiences, while less attention should be given to solely alleviating symptoms of depression, anxiety, or burden among caregivers.

The Role of Culture. The caregivers interviewed identified a culture of caregiving. Many of them argued that the tradition of caregiving could be traced to their own racial or ethnic origin. Similarly, Levkoff et al. (1999) found that African-American, Irish-American, Puerto Rican, and Chinese-American caregivers, all endorse the norm of 'caring for our own' and identified ethnicity as their reason for informal care.

The caregivers interviewed associated their tradition of care with their ethnic origin, yet our study suggests that this tradition is common across ethnic affiliation and, therefore, is not particularly related to a specific ethnic group. One possibility is that ethnicity serves as an educational tool among the different ethnic groups in the United States. Identifying ethnic origin as a unique characteristic, responsible for the tradition of informal care, provides a rationale for caregiving and prepares the individual to the caregiving role. Emphasizing ethnic origin is only one mechanism responsible for the socialization of family members into caregiving. The present study suggests that role modeling and early experiences with informal care are other methods of socialization into the caregiving role.

It also is possible that ethnic group differences were more substantial in country of origin, but differences have subsided substantially following exposure to values and life style of the majority culture. This hypothesis was partially supported by the caregivers' report of a generational change in

caregiving. Many of the caregivers argued that the younger generation does not follow their tradition of care and expressed a fear that the younger generation would not provide care to them at times of need. The caregivers interviewed also suggested implicitly that as level of assimilation to the majority culture increased, informal support was less likely to be provided. Similarly to our findings, Magilvy, Congdon, Martinez, Davis, and Averill (2000) reported changes in the tradition of care among the younger generation of Latino caregivers who often face geographical and financial limitations that restrict their ability to provide care to their family members. Burton and Sorensen (1993, p. 53) reported a similar phenomenon in African American families, stating that the younger generation does not tend to follow the tradition of care for one's own family members, held by the older generation.

Familial Conflict. The present study suggests that availability of family support is not necessarily more prevalent among members of ethnic minority groups. This is supported by a plethora of recent research (Hinrichsen & Ramirez, 1992; Levkoff et al., 1999) that disputes the common notion that members of ethnic minority groups enjoy greater familial support.

The present study also suggests that, unrelated to the levels of familial involvement, familial conflicts are present across ethnic group affiliation. However, the nature of the conflict varies based on level of familial involvement. When care is provided by a primary care provider who receives little or no assistance from other family members, the conflicts usually concern the distribution of work within the family system. In contrast, when several family members share the caregiving role, the conflicts concern the distribution of work between formal services and the family system.

Interestingly, only one caregiver reported having familial conflicts with the care recipient. This could be due to the fact that the majority of care recipients in the present study were either medically or cognitively incapacitated. Conflicts are less likely to occur when the care recipient reaches such severe levels of impairment.

Only one participant mentioned religious and spiritual involvement as useful tools when dealing with the stress associated with caregiving. This finding is consistent with previous studies that showed that despite the importance of religiosity among members of certain ethnic minority groups (Navaie-Waliser, Feldman, Gould, Levine, Kuerbis, & Donelan, 2001), religious services are rarely used as a source of support at times of distress (Ayalon, 2002; Levkoff et al., 1999). Future research should evaluate possible barriers to religious service use at times of mental distress.

The majority of the caregivers in the present study chose a more passive path for conflict resolution. Possibly, the caregiving dissonance, which exposes caregivers to multiple contradictory feelings and thoughts, has made it easier for these caregivers to understand and accept behaviors and opinions of other members of the family.

Formal Service Use. Despite multiple stressors and difficulties associated with family caregiving, all caregivers interviewed tried to keep caregiving in the family system as long as they could. Reasons for underutilization of formal services were dissatisfaction with the quality of formal care, the view of caregiving as a personal responsibility, lack of visibility of formal services, lack of culturally sensitive services, lack of financial resources, and the wish to keep the care recipient in his or her natural environment.

The most common explanation for not using formal services was the view of caregiving as a personal responsibility. Furthermore, several caregivers argued that as care recipient's condition deteriorated, familial responsibility to care increased and their perceived 'right' to use formal services decreased. Based on this report, those caregivers who deal with the most impaired care recipients and need formal services the most are the ones who are the least likely to use formal services. Educating the caregivers not only about the availability of formal services and financial support, but also about the legitimacy of using these services should take place early in the disease process of the care recipient.

In the present study, only one caregiver expressed concerns regarding lack of availability of culturally sensitive services. Other reasons, such as belief in personal responsibility and financial limitations likely prevent caregivers from using formal services. Without actually accessing formal services, caregivers are less likely to be aware of or experience lack of culturally sensitive services.

SUMMARY

Contrary to the plethora of research that emphasizes ethnic and racial differences in the caregiving experience, the present study identified common characteristics of caregiving across three different ethnic groups. The common experiences across the three ethnic groups support the view of caregiving as a culture that employs common traditions, customs, beliefs, and behaviors. Similarly to the present study, Albert (1990) has argued for the view of caregiving as a cultural system by demonstrating shared knowledge and perspectives among caregivers. However, Albert (1990) did not take into consideration the role that ethnicity plays in the caregiving experience. By focusing on similarities across three ethnic groups,

the present study provides stronger support to the notion of caregiving as a cultural system.

The study does not argue that ethnic differences do not exist. However, it is argued that in order to better understand the phenomena of caregiving, more attention should be given to the common characteristics of the caregiving experience. Understanding and appreciating ethnic or racial group differences is desirable and important, but so is the understanding and appreciation of similarities in the caregiving experience. Evaluating and understanding both perspectives likely will provide a clearer picture of the caregiving experience.

The caregivers interviewed in the present study were able to identify a culture of caregiving that did not differ across the three ethnic groups. Furthermore, they all faced similar challenges, such as familial conflicts and low levels of formal service use in addition to reported cognitive, emotional, or behavioral dissonance. Possibly, similarities across the three ethnic groups can be explained by the assimilation perspective (Park, 1950). This perspective argues that differences between ethnic group disappear as members of the minority culture assimilate the values and traditions of the majority culture. In order to better understand the role that exposure to the majority culture plays in the caregiving experience, future research should compare the caregiving experience of minority groups in the United States to the experience of these ethnic groups in their country of origin. In addition, level of acculturation and the interaction of age with ethnic origin should be taken into consideration when evaluating variations in the caregiving experience.

Interestingly, in contrast to past research that often distinguished between a spouse caregiver to a child caregiver, the present study found that many caregivers provide care to multiple family members and, therefore, cannot be defined as either a spouse or a child caregiver. In addition, the study found that several caregivers provided care to a sibling, a category that is less frequently studied. Research should recognize that caregivers provide different levels of care to multiple family members and, therefore, cannot be characterized as providing care to a single family-member.

The relative small number of caregivers from each ethnic group did not allow the evaluation of the unique characteristics of each ethnic group separately. Future research should replicate the study, using a larger number of caregivers and evaluating both similarities and differences across the three ethnic groups. An additional limitation of the present study is the fact that all caregivers were referred by Metropolitan Family Services. This is a self-selected sample of caregivers who chose to seek supportive formal services. This group is likely to be relatively homogenous

in certain aspects, such as caregiver's level of distress, level of impairment of care recipient, and values related to use of formal services. A more thorough understanding of the culture of caregiving will be gained by interviewing both caregivers who use formal services and those who do not.

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