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Original Article

# *Marianismo* and Caregiving Role Beliefs Among U.S.-Born and Immigrant Mexican Women

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## Abstract

**Objectives:** We aimed to explore how women of Mexican-origin conceptualized caregiving as a construct in terms of cultural beliefs, social norms, role functioning, and familial obligations. We examined the personal experiences of U.S-born and immigrant Mexican female caregivers to identify how these 2 groups differed in their views of the caregiver role.
**Methods:** We conducted 1-time in-depth interviews with 44 caregivers living in Southern California. Our study was guided by *marianismo*, a traditional role occupied by women in the Mexican family. We analyzed data from a grounded theory approach involving the constant comparative method to refine and categorize the data.
**Results:** The majority of all caregivers had similar views about caregiving as an undertaking by choice, and almost all caregivers engaged in self-sacrificing actions to fulfill the *marianismo* role. Despite these similarities, U.S.-born and immigrant caregivers used different words to describe the same concepts or assigned different meanings to other key aspects of caregiving, suggesting that these 2 groups had different underlying motivations for caregiving and orientations to the role.
**Discussion:** Our findings highlight the complexity of language and culture in underlying caregiving concepts, making the concepts challenging to operationalize and define in a heterogeneous sample of Latinos.

**Keywords:** Caregiving—In-depth interviews—Minority aging—Qualitative methods

Latino older adults live longer than the total population but they do so with greater morbidity (Herrera, Lee, Palos, & Torres-Vigil, 2008). Latino older adults also utilize nursing home care and private pay care at lower levels compared with non-Latino white older adults (Angel, Rote, Brown, Angel, & Markides, 2014). The burden of care seems to be greater for Latino caregivers compared with their non-Latino white counterparts because Latino caregivers tend to provide more care and report worse physical health (Pinquart & Sörensen, 2005). Although caregiving research has been conducted in racial/ethnic populations, the majority of caregiving research has included homogenous samples of Latinos or African Americans (Dilworth-Anderson, Williams, & Gibson, 2002), resulting in an inability to assess within-group characteristics (Pinquart & Sörensen, 2005). The heterogeneity of the Latino population, including Mexican immigrant and U.S.-born groups, has been documented on a host of socioeconomic factors that have been associated with long-term health outcomes (Williams, Mohammed, Leavell, & Collins, 2010). Elder caregiving is also likely to differ within and across Latino subgroups. For example, findings from an exploratory study suggested that Mexican women's concepts of elder care and caregiver burden differed from other caregiving studies using U.S. samples (Mendez-Luck, Kennedy, & Wallace, 2008, 2009).

Nativity, or country of birth, is particularly relevant for Mexican-origin caregivers because it signals potentially different social upbringings and cultural teachings about the caregiver role. Prior research supports this idea and has shown that health, health behavior, and family formation

among Latinos differ by nativity or generational status (Arcia, Skinner, Bailey, & Correa, 2001; Lara, Gamboa, Kahramanian, Morales, & Hayes-Bautista, 2005; Robinson & Knight, 2004). Angel and colleagues (2014) found that immigrant Mexican elders were more dependent on their adult children for help and far less likely to call on other family relatives and community-based providers for help than U.S.-born Mexican-origin elders. Another study of Mexican American women caregivers found that both highly acculturated and lower acculturated caregivers felt that caregiving was an integral part of being a good daughter with the most rewarding aspect of caregiving being the ability to fulfill role obligations (Jolicoeur & Madden, 2002).

Theoretical perspectives have been offered to frame the cultural context of care in Latino families. Familism, culture of poverty and strength resiliency are examples of frameworks used to explain family structure, role functioning, and obligations for such responsibilities as child rearing, god parenting, surrogate grand parenting, and to a less extent, elder caregiving (Delgado, 2007; John, Resendiz, & De Vargas, 1997; Shurgot & Knight, 2005). However, these theoretical perspectives have been criticized for over-generalizing conditions of the family which are not substantiated or for perpetuating stereotypes about the Latino family (Rochelle, 1997; Wallace & Facio, 1987). Furthermore, these perspectives are limited in their ability to understand the dynamic within-group variations on elder caregiving.

We undertook the present study to provide formative research regarding Latinas' orientation to the caregiver role and the cultural beliefs that shape their caregiving experiences. Building on our prior research with Mexican caregiving women (Mendez-Luck et al., 2008, 2009), and drawing from the literature on social roles in Mexican families, we used a grounded theory approach and a social constructionist framework to explore how women of Mexican-origin conceptualized caregiving as a construct in terms of cultural beliefs, social norms, role functioning, and familial obligations. The aims of this article are to (a) describe views of the caregiver role among U.S.-born and immigrant Mexican women caregivers living in Southern California; and (b) examine how these views align by nativity.

### *Marianismo*

Our study was informed by *marianismo*, a traditional gender role in the Mexican family (Gutmann, 1997; Hubbell, 1993) that is fundamental to the social organization of Latino cultures (Staton, 1972). Women are socialized into the *marianismo* role beginning in early childhood, which guides normative behaviors of femininity, submission, weakness, reservation, and virginity (Bridges, 1980; Le Vine, Sunderland Correa, & Tapia Uribe, 1986; Nader, 1986; Peñalosa, 1968). An important aspect of *marianismo* is the sense of responsibility to the family (Hubbell, 1993). In this role, a woman is expected to be submissive and deferential to her husband, and to perform self-sacrificing behaviors that benefit her family, presumably including elder care (Hubbell, 1993; Peñalosa, 1968). This role is based on the emulation of the Virgin Mary in the Catholic religion and has been referred to as *la madre abnegada* (Hubbell, 1993), meaning "self-sacrificing mother." Both terms refer to the perfect self-sacrifice of the Virgin Mary on the behalf of God by becoming the mother of Jesus. Thus, the ideal Mexican mother is one who sacrifices her own needs and happiness for the sake of her children and family (Hubbell, 1993). We chose *marianismo* as a guiding framework for our study because religion is intertwined with Mexican culture. Catholicism has a long history in Mexico dating back to the period of colonization (Krause & Bastida, 2011). The Virgin Mary is seen as an especially important religious and cultural symbol in Mexican society (Campesino & Schwartz, 2006). Thus, beliefs surrounding the Virgin Mary are interwoven in the fabric of Mexican culture, making them indistinguishable from other cultural tenets. As such, *marianismo* as a cultural value is likely shared to some degree among Mexican-origin women, irrespective of actual religious affiliation or level of religiosity.

## Method

We applied a social constructionist framework in this study to examine how a sample of Mexican-origin women organized their behaviors and interpreted their caregiving experiences to create their social realities as caregivers. Social constructionism is derived from sociological theory to understand the ways in which individuals and groups participate in creating their social life-worlds (Schwandt, 2000). Part of an individual's social reality or life-world is his or her "lived experience," which refers to specific topics of interest, such as caregiving (Patton, 1990). This framework enabled us to examine Mexican-origin women's lived experiences as caregivers, in terms of what constituted caregiving and how they fulfilled the *marianismo* role through caregiving behaviors. We used this framework to guide this study, including developing the research questions, the questions included on the interview guide, and the interpretation of results. We used the qualitative method of in-depth interviews, which has been shown to be a valuable approach to understanding caregiving experiences (Abel, 1991). In-depth interviewing techniques can be especially effective in revealing both the emotional and the symbolic meanings of elder caregiving that are not detected in typical survey approaches (Knight & Sayegh, 2010).

### Study Site

The site for our study was East Los Angeles, California (East LA), an unincorporated area of Los Angeles County geographically located east of Downtown Los Angeles. East LA has the highest percentage of Latinos (97%) among the top 10 places in the United States with 100,000 population or

more (Ennis, Ríos-Vargas, & Albert, 2011). Ninety-one percent of all Latino residents in East LA are of Mexican descent (American Community Survey, 2011a). Forty-four percent of East LA's population is foreign-born, and 89% speak a language other than English at home (U.S. Census Bureau, 2010), compared with 36% and 75%, respectively, of the total U.S. Latino population (American Community Survey, 2011b, 2011c). Overall, the percentage of persons in East Los Angeles living below the federal poverty level (24%; U.S. Census Bureau, 2010) is similar to all unrelated Latino individuals nationally (23%; American Community Survey, 2011d).

## Sample Recruitment

We recruited participants in three phases from March 2006 to August 2012, although the majority of interviews occurred between 2006 and 2007. Women who met the following criteria at the time of interview were eligible to participate in the study: (a) minimum of 18 years old; (b) self-identified as the primary person responsible for the overall care of a dependent, elderly family member; (c) of Mexican descent, either born in the United States or in Mexico; and, (d) a resident of the greater East Los Angeles area. We defined a dependent, elderly family member as a person at least 60 years old related through blood or marriage who needed help with one or more activities of daily living (ADL) or instrumental activities of daily living (IADL). ADLs referred to basic care functions, such as feeding, bathing, dressing, transferring, toileting, and personal hygiene (Katz, 1983), and IADLs referred to more complex activities, such as transportation, cooking, grocery shopping, housework, and financial management (Lawton & Brody, 1969). We made an exception to the age requirement three times when care receivers were not yet 60 years old but their caregivers identified them as "old." We developed broad eligibility criteria because we were interested in examining a range of caregiving experiences. Enrolled participants received a small financial incentive of $35 for a completed interview.

We focused on identifying and enrolling caregivers of community-dwelling, noninstitutionalized elders, and spent a considerable amount of time establishing a presence in the community. During the 2-year period when the majority of interviews were conducted, we documented over 63 visits to the community for 318 hr, not including the time spent conducting interviews (Mendez-Luck et al., 2011). We recruited women using multiple approaches, including collaborating with community-based organizations on targeted recruitment events and independent investigator-initiated efforts, such as face-to-face contact with community residents on street corners and bus stops and at community health fairs. Our community partners were mostly not-for-profit human services organizations that served senior citizens, caregivers, or low-income Latino families in the greater East Los Angeles area. More detailed information on our community partnerships is documented elsewhere (Mendez-Luck et al., 2011).

We also used snowball sampling to recruit participants (Bernard, 1995). This technique has been shown to be effective for locating community-dwelling caregivers and elders who may not access social or medical services (Mendez-Luck et al., 2011). After an enrolled participant completed her interview, we asked if she knew of another caregiver who might be interested in the study. Former participants and ineligible but interested women aided in recruitment through word of mouth to their friends and family.

Lastly, we used purposive sampling to find study participants that represented a range of caregiving situations to explore concepts that emerged from previous interviews. Specifically, we sought out individuals to increase variation in the sample to pursue theoretical leads in the data to achieve theoretical saturation (Roy, Zvonkovic, Goldberg, Sharp, & LaRossa, 2015).

## Data Collection

We obtained informed consent from study participants using procedures approved by the University of California, Los Angeles and Oregon State University Institutional Review Boards. We collected data from semistructured interviews. We adapted a guide from one used in a prior study of Mexican caregivers (Mendez-Luck et al., 2008, 2009). We first administered the original guide to three Mexican American women living in East Los Angeles, and then revised it for use in this study. The final interview guide covered four topics: (a) story of becoming a caregiver; (b) forms of assistance and contexts of caregiving; (c) social and cultural beliefs about aging; and (d) beliefs about the caregiver role. Specifically, we asked study participants a series of open-ended questions about their families, the care they provided to care receivers, and their caregiving situations. We used probing questions to elicit a richer set of responses for each topic.

The first author or a native-speaking research assistant conducted the interviews, which took place in the participants' homes or locations of their choice, such as a community center, coffee shop, or church. The first author trained the research assistant in field research and in-depth interviewing techniques prior to conducting the interviews.

## Data Analyses

All interviews were tape-recorded, conducted in English or Spanish, and lasted an average of 84 min. The interview audio tapes were transcribed verbatim by a professional transcriber or the native-speaking research assistant. Data were managed in Atlas.ti (Friese, 2012) to facilitate the analysis. Data were analyzed in the language of the interview using a grounded theory approach (Strauss & Corbin, 1994), which involved an iterative process of examining the transcripts from the onset of data collection. Three bilingual research assistants independently coded the transcripts. The first author met repeatedly with them and a fourth research assistant to resolve coding differences and reach consensus on findings using a constant

comparative method (Kolb, 2012) to refine and categorize the data. In a parallel sequence, we compared the emerging concepts of caregiving by nativity, where except for one case, English-language transcripts corresponded to the U.S.-born women and Spanish-language transcripts corresponded to the immigrant women. One exception was an immigrant woman who was fluent in both languages and was interviewed in English. As we reached consensus on our findings, we examined those findings by nativity. This iterative process was aided by theoretical sampling to reach saturation of the data which occurred at Interview 18 for the English interviews and Interview 26 for the Spanish interviews.

## Results

### Caregiver Characteristics

A total of 44 Mexican-origin women participated in this study, 18 born in the United States, and 26 born in Mexico. The study sample tended to be long-time residents of their respective neighborhoods, with 30 participants living in East Los Angeles, and 14 participants residing in nearby communities. U.S.-born study participants reported having lived in their neighborhoods for an average of 36.5 years, with a broad range of 1–68 years. Immigrant participants reported having lived at their present locations for 22 years on average, with a range of 1.7–45 years. Immigrant caregivers were slightly younger, slightly less educated, and had lower monthly incomes. The mean age of participants was 52.6 years, with a range of 23–89 years, with U.S.-born caregivers being slightly older than those born in Mexico. The study participants' educational levels ranged broadly from no formal education to 21 years (graduate school), with an average of 10 years. However, 34% of study participants had less than a 9th grade education, the majority of whom were immigrant participants. Eighty-three percent of study participants did not work outside the home, however U.S.-born caregivers more commonly reported working part-time or full-time jobs than those born in Mexico. The median monthly income for caregivers' households was $1,600, with a broad range from $700 to $5,400, with households of U.S.-born caregivers having average incomes of at least $1,000 more a month than immigrant households. We considered household income as the pooled monies between family members, such as caregivers and their spouses, care receivers and their spouses, and other related persons living in the household. However, nine caregivers lived in households with other family members who did not contribute to the household's income as a whole. Thus, the average number of persons supported on the pooled monthly income was three whereas the average size of households was four persons. The size of the household and the number of persons supported on the pooled incomes had the same range of 1–14 persons.

### Care Receiver Characteristics

The mean age of care receivers was 73.4 years, with a range from 55 to 93 years. The majority of care receivers were born in Mexico and had an average of 6 years of formal education. Care receivers of immigrant caregivers tended to be younger, less educated and sicker than those of U.S.-born caregivers. A higher proportion of care receivers of immigrant caregivers had diabetes (42%), mobility problems (27%), arthritis (19%), and pain (12%) compared to the care receivers of U.S.-born caregivers (28%, 11%, 11%, and 5%, respectively). Care receivers of immigrant caregivers had higher numbers of comorbidities and needed more ADL help, compared with the care receivers of U.S.-born caregivers, including help with kidney dialysis.

### Caregiving Characteristics

The majority of participants (32) gave care to nonspousal relatives. More immigrant caregivers (31%) reported providing care for husbands than U.S.-born caregivers (22%), however the majority of all caregivers provided care to a parent. Mothers were the most common care receiver among both caregiver groups. The mean number of years spent caregiving was 8.3, with a broad range from 8 months to 62 years, reflecting a mix of short-term and long-term caregiving situations. Most caregivers had been caring for a family member between 1 and 3 years (U.S.-born, 61%; immigrant, 46%), however five caregivers (3 U.S.-born and 2 immigrant) reported providing care for over 21 years. More immigrant caregivers (85%) shared households with their care receivers than did U.S.-born caregivers (72%).

### Views of the Caregiver Role

#### Overall findings

We asked study participants a series of open-ended questions to investigate their beliefs about caregiving as a form of responsibility, including whether they viewed being a caregiver as an obligation, commitment, or duty to their family member. We asked what these different terms meant to them in the context of caregiving, the expectations of care by others, and the role of women in Mexican culture. Study participants' discussions revealed that these terms had specific connotations in the context of caregiving. Most caregivers viewed the term obligation in negative ways. For most participants, an obligation referred to having a lack of choice or an unwanted responsibility, as well as caregiving under force or stress or because no other alternatives existed. On the other hand, study participants viewed the term commitment more favorably than obligation because commitment involved a willingness to give care whereas obligation did not.

The majority of all study participants did not view caregiving as an obligation but as a duty, responsibility, or commitment toward their family members. Their

discussions about caregiving revealed a sense of willingness and choice that aligned with their favorable views of commitment, and most study participants indicated that they took on the caregiver role because they wanted to. For example, 31 year-old Gloria cared for her mother who suffered from foot problems. She started caring for her mother after her father passed away. Gloria did not feel that providing care to her mother was an obligation because according to her:

> . . . if you feel really connected to your mother or your father, or whoever you're taking care of, it shouldn't feel like an obligation. It should feel like it's . . . something that you want to do because you want them to be happy. . . . It should be something that you want to do, not something that you're forced or have to do.

Implicit in this quote was the notion that obligation involved being coerced into doing something, which was a very common point of view among study participants. Another caregiver, Victoria, explained that caregiving was better defined as a commitment because it was her choice and decision to provide care to a family member. Victoria, a U.S.-born caregiver, had a history of caring for her parents. She had cared for her mother until her mother died, and at the time of the interview, had been caring for her 84 year-old father who suffered from dementia, diabetes, and polio-related disabilities. In the following quote, she described the differences between commitment and obligation:

> A commitment is actually doing something that you want to do. Something that maybe you need to do and stand by it. Obligation . . . is something that somebody gave you [to do]. "Okay. Here, this is yours. Deal with it." Commitment . . . I was committed to taking care because I wanted to care, because they [parents] needed the care. That's what my commitment was. . . . They basically needed the help when they didn't have no resources, had nobody to turn to, not even their own sons. Their own family were too busy . . . they needed this help. Regardless of what I went through with them, they had trips, the anger trips, the fighting, the arguing. I felt I needed to be here. This was my feeling.

In their discussions of obligation, commitment, and duty, some study participants described caregiving as part of their broader role in the family (e.g., as wife or daughter), consistent with a *marianismo* perspective. Participants stated that they gave care for many reasons, including to repay their family members for past contributions to the family, and to show love and affection for their family members. For other study participants, caregiving came from the heart or was done out of enjoyment. One such caregiver was Luz Maria. At the time of the interview, Luz Maria was 38 years-old and had been caring for her 62 year-old mother for five years. She stated:

> Everything comes in one, duty, commitment, necessity. It almost means the same to me because it is an obligation. . . . It's like an obligation that I feel that I alone have to do for my mother. It's not like she is asking me for it, but . . . I am a daughter and I have to help my mother. . . . Like the Ten Commandments indicate, you must obey your father and mother so that you live a good life. So I am doing this.

Caregiving for Luz Maria was tied to her cultural views of the daughter role, which was consistent with the principles of *marianismo*. Luz Maria's quote also reflected the sentiments of some caregivers who did not draw clear distinctions between the terms obligation, commitment, and duty.

**U.S.-born versus immigrant groups**

Further analysis revealed that participants from the two groups appeared to have fundamentally different orientations to the caregiver role. All but one U.S.-born study participants viewed obligation strictly in negative terms. On the other hand, participants from the immigrant group shared a range of views on obligation, some of which did not have a negative connotation. For example, eight immigrant participants explained that having an obligation stemmed from teachings and customs instilled during childhood. Thus for these caregivers, obligation in the context of caregiving was not negative; it meant carrying out family values. None of the participants in the U.S.-born group described obligation in this way.

Similarly, the two groups viewed the concept of duty differently. Immigrant participants often discussed caregiving as a moral duty related to role fulfillment. In the context of caregiving, they referred to duty as fulfilling a promise, repaying for past achievements, and acting out of love. However, only one U.S.-born study participant expressed that caregiving was part of her duty as a wife. In fact, most U.S.-born caregivers viewed duty in negative ways similar to obligation. For example, U.S.-born Della cared for her mother Angie who suffered from mobility limitations. Della indicated that she did not like using the words duty or obligation to describe her decision to care for Angie and explained that, ". . . a duty is pretty much the same thing [as an] obligation. . . . I think it's the same. . . . Yeah, duty does sound like forcing [you] to do it. Yeah, it doesn't sound like a good word."

The differences in views of caregiving as an obligation, duty, or commitment between the U.S.-born and immigrant groups revealed that caregiving concepts were complicated and embedded in different cultural frames. For example, a small number of immigrant caregivers (6) viewed caregiving as an obligation although the majority of caregivers from both groups did not. These caregivers explained that their obligation as caregivers was tied to being a wife or daughter and involved love and affection. Thus, although this small group of immigrant caregivers indicated that caregiving was an obligation, their explanations aligned with

other immigrant and U.S.-born women who did not view caregiving as an obligation, suggesting that caregiving concepts were not easily encompassed by one term (i.e., obligation, duty, or commitment). Nonetheless, the ways in which participants from these two groups shared their views on caregiving revealed fundamentally different orientations to the role and highlighted the importance of language as a cultural frame for caregiving discussions.

## Sacrifice

**Overall findings**

All study participants engaged in a number of self-sacrificing behaviors to fulfill the *marianismo* role. Their lived experiences as caregivers were imbued with sacrifices and losses to their personal lives and interpersonal relationships in the interest of serving elderly family members. Most participants shared that because of caregiving, they endured losses in terms of time, money, physical space, and private time. However, study participants viewed sacrifice as necessary to improve the elders' health or to safeguard it from further decline, reflecting a focus on having the elders' "needs met." Preventing the elder from feeling abandoned, unloved, or lonely were other important objectives that caregivers achieved through their sacrificing actions.

Caregivers viewed sacrifice as material and symbolic losses. The most common examples of material losses were quitting jobs, having financial difficulties, reducing the number of outings with friends or time spent with spouses, children, or on hobbies or sleeping. Some caregivers reported entering into a shared living arrangement with elderly family members as a sacrifice of space. Virtually all study participants identified at least one material loss to their personal lives as a result of becoming a caregiver. The following excerpt from Connie's interview illustrated the material losses caregivers experienced to fulfill the *marianismo* role:

> Before my mother came [to live with me], I used to work for the City Hall…and then after [she fell], [my husband and I] discussed it, and my mother was going to have to come live with me because she couldn't live with my son. I gave my notice and I retired. And I have been taking care of my mother since. [Interviewer: Oh, so you retired to take care of your mom. Otherwise, you would have kept working?] Yes, I liked my job.

Symbolic losses referred to emotional and intangible losses endured as a consequence of caregiving. The most common examples were loss of freedom, happiness, and self. Virtually all caregivers also reported experiencing social isolation as a result of their daily caregiving responsibilities. One caregiver apologized for talking a lot in the interview and said, "I'm sorry. The reason why I talk so much is because I don't get out of the house." The following three excerpts characterized the symbolic losses caregivers endured because of their caregiving responsibilities:

> I don't have a life. My life is my mom.
>
> My parents have consumed my life.
>
> I can't go [out] at the drop of a hat. I had my freedom [but] I have no freedom [now].

**U.S.-born versus immigrant groups**

Although caregiving came at an emotional and social cost to all study participants, the two groups described loss differently. U.S.-born caregivers discussed sacrifice in terms of losing their identity and giving up their lives. Their views of sacrifice were almost exclusively negative and a detriment in their lives. For example, Ofelia was a 35 year-old single woman who had been caring for her parents since she was 14 years old. Although Ofelia had two older siblings, she had been responsible for caring for her parents since she was a teenager. She shared,

> They [her family] expect a lot [from me], see? And my mother's sister, my *tía* (aunt) Julia, she took care of her parents until they passed away. She never had her own family and wanted a family. And I said, "I'm not going to be like my *tía*. . . . I'm not going to be the martyr".

Ofelia's reference to being a martyr resonated with being a *mariana*, which she rebuked despite the cultural expectation. Ofelia's view of her Aunt Julia's life suggested that Ofelia was conflicted about her cultural values, the *marianismo* role, and her own personal desires. Another caregiver's experience suggested that *marianismo* was a significant source of suffering for Mexican American caregivers. Olga was 50 years old, born in East Los Angeles, and had never been married or had children. She had lived with her parents off and on for her entire adult life. She began caring for her mother Rosa 10 years prior to the interview, after Rosa was diagnosed with Alzheimer's disease. For the past 4 years, Olga had been living with Rosa as a full-time caregiver. Olga asked the interviewer, "Is it [because of] the Mexican culture that we suffer? That constant suffering? There's a melancholy [there]." When asked where the suffering came from, she responded:

> Honestly? I think it's church. I think it's learned. I think it's "the meek shall inherit the poverty." There's a lot of happiness, a lot of "let's celebrate," but underneath all of that, you celebrate because there's an undercurrent [that] this life is hard, hard work. I really honestly believe that. I do think that the church adds to it. Like I said, "the meek shall inherit, or we shall have a better life in the afterlife. Do what is expected of you here, suffer, give up." I think it's a coping mechanism.

These excerpts illustrated the negative views of sacrifice expressed by other Mexican American caregivers. This group of study participants satisfied an important tenet of *marianismo* but at great personal costs.

On the other hand, immigrant caregivers' discussions of sacrifice did not suggest a conflict between cultural expectations and role fulfillment. Rather, they described the toll

of their sacrificing behaviors, such as the loss of sleep, feelings of exhaustion, and living a confined existence. Several study participants in the immigrant group mentioned not having "*ganas*," which referred to not having the will. Some participants indicated that they did not have the will to do anything ("*no tengo las ganas para hacer nada*"), while others indicated not having *ganas* to do specific things. In all of these cases, the lack of will was attributed to caregiving. While not having *ganas* could be viewed as a symptom of depression, only one woman mentioned feeling a little depressed by caregiving ("*me deprime*").

Other immigrant caregivers were more matter of fact about their sacrifices. For example, some of them indicated that nothing much had changed in their lives when they began caregiving, except for having to leave their jobs or having more work to do around the house. A few of them mentioned emigrating from Mexico or moving from another part of the state to become full-time caregivers. In summary, immigrant study participants' struggles were limited to the physical and emotional consequences of their caretaking actions and the changes to their daily life routines. The lack of explicit complaints about caregiving suggested a normative view of *marianismo* rather than a conflict between cultural expectations and role fulfillment, as was seen in the U.S.-born group.

## Discussion

In this study, we used *marianismo* as a frame for understanding the lived experiences of Mexican-origin caregivers and their fulfillment of the caregiver role. Overall, the majority of all caregivers had similar views about caregiving as an undertaking by choice. These findings are supported by previous research showing that cultural factors indeed shape the caregiving experiences of Mexican women (Henderson, 1992; Jolicoeur & Madden, 2002) and that the commitment to providing elder care is based on intergenerational reciprocity (Mendez-Luck et al., 2008, 2009; Borrayo, Goldwaser, Vacha-Haase, & Hepburn, 2007; Neary & Mahoney, 2005). Our findings are also consistent with research showing that caregiving has positive attributes, such as giving meaning and purpose to caregivers (Brown, Nesse, Vinokur, & Smith, 2004). Additionally, our findings on sacrifice are consistent with other research showing that caregiving involves financial hardship (Lee, Tang, Kim, & Albert, 2014), and places emotional and physical demands on caregivers (Pinquart & Sörensen, 2005).

We move this body of literature forward by examining within-group differences in views of the caregiver role, based on nativity. Moreover, a contribution of our study is the finding that while Mexican immigrant and Mexican American caregivers expressed similar viewpoints overall and fulfilled the *marianismo* role, they used different words to describe the same concepts or assigned different meanings to other key aspects of caregiving. This finding suggests that these two groups had different underlying motivations for caregiving and orientations to the role, which is important for two reasons. First, we uncovered a within-group difference of caregiving orientation that has generally been overlooked in prior studies (Dilworth-Anderson et al., 2002). Second, this finding supports the suggestion that measurement issues may in part explain the equivocal findings on depression and burden among Latino caregivers. Specifically, our findings highlight the complexity of language and culture in underlying caregiving concepts, making the concepts challenging to operationalize and define in a heterogeneous sample of Latinos.

One potential explanation for the divergence between the two caregiver groups is acculturation, which may create different expectations of the role over time. Research has demonstrated associations between acculturation and caregiver burden (Jolicoeur & Madden, 2002), depressive symptoms (Hahn, Kim, & Chiriboga, 2011), use of home care services, and values about the family (Crist et al., 2009). Our study may have revealed one manner in which acculturation plays out among some immigrant and U.S.-born caregivers such that exposure to different sets of cultural norms, social role expectations and environments influences their world views of elder caregiving. From a social constructionist perspective, the cultural values embedded in social roles and the family environment shaped women's views on caregiving such that as a collective experience, the U.S.-born women emphasized different aspects of the caregiving experience from the immigrant women.

These diverging orientations to the caregiver role by U.S.-born and immigrant caregivers are supported by the broader literature on the traditional Mexican family. *Marianismo* is instilled from early childhood and places particular expectations on women that include self-sacrificing behaviors that benefit the family as a whole (Bridges, 1980; Hubbell, 1993; Peñalosa, 1968). The immigrant caregivers' discussions about the caregiver role were consistent with this traditional gender role and a collectivist view. However, the Mexican American women did not fit this profile as well. Their discussions were imbued with a value of individualism, a hallmark of Western cultural values (Knight & Sayegh, 2010).

Another potential explanation for our findings is the influence of structural factors in the caregiving experience. Research has found that sociodemographic forces are altering the norms and practices that surround intergenerational relations and intra-familial exchanges, which may affect the experiences of Latino caregivers (Angel et al., 2014). Education and income are important structural factors that create opportunities for accessing resources that may shape caregiver role expectations and behaviors over time. The U.S.-born caregivers in this study were more educated and had higher incomes, suggesting they were better resourced compared with the immigrant caregivers. Using a social constructionist lens, U.S.-born caregivers may have had increased exposure to available services or more interaction with services by virtue of being better resourced. This exposure in

turn influenced their expectations and focus of caregiving. Using this same argument, immigrant caregivers also assigned meaning to the caregiver role and related activities within the context of their life situations. It was possible that their focus on the care receivers' well-being and on the emotional aspects of caregiving was in response to limited life options that framed their overall life-worlds (Schwandt, 2000).

### Limitations

This study has some limitations. First, men were not included in this study, which prevented us from exploring how gender play outs in the caregiving experiences of Mexican-origin caregivers. More research is needed to examine how caregiving aligns with the social role expectations of men and women in this Latino subpopulation. Additionally, we only interviewed each study participant one time. Multiple interviews would have given study participants the opportunity to think through their experiences, providing richer data. This study did not investigate the experiences of women who had opportunities to become caregivers but did not do so. Therefore, we cannot ascertain whether the values surrounding *marianismo* are equally shared by other Mexican Americans, or if *marianismo* is simply used as a justification for those who become caregivers. Although the interview guide was piloted-tested in English and Spanish prior to collecting data, we acknowledge that the cultural nuances of each language set up inherent differences in the collected data, which may have affected the interpretation of results. Lastly, the generalizability of our study is limited due to the sample's characteristics that could have influenced the ways they socially constructed their lived realities.

### Conclusions

Our findings suggest that the motivations and enactment of elder care in Latinos of Mexican origin are complicated, providing evidence that not all caregivers in this Latino subgroup are alike. Our results further suggest that a cultural shift may be occurring at least in part due to the acculturation experience, consistent with the findings by Angel and colleagues (2014). Nonetheless, we found that U.S.-born and immigrant caregivers fulfilled the *marianismo* role, and shared fundamental cultural views on caregiving by choice and meeting elders' needs. Thus, our research highlights the importance of context in the caregiving situation, which may influence the enactment of care by Mexican-origin women. Moreover, our research identified specific cultural domains of caregiving that merit further exploration, particularly the relationships of duty, obligation, commitment, and sacrifice to acculturation. This line of research will become increasingly important because the demand for informal caregiving will likely increase in the future as Latino adults arrive at old age in greater numbers and in poorer health than their non-Latino peers (Herrera et al., 2008).

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