

Native Hawaiian Male Caregivers: Patterns of Service Use and Their Effects on Public Policies

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Abstract

The purpose of this study is to compare and contrast the effects of caregiving for Native Hawaiian males, as compared to Asian and Caucasian males, and to determine how these differences affect service use patterns and opinions on government policies. Using a survey instrument adapted from a national data collection effort, data were collected from a probability sample of 600 caregivers in Hawai'i, of which 155 were male. Analysis was limited to the 148 male caregivers with ethnicity data: Native Hawaiians (N=36), Caucasians (N=50), and Asians (N=62). Findings indicate that of the three groups studied, Native Hawaiians were the least burdened by caregiving. They were most likely to use training services and transportation, but did not generally use formal services because services were either unavailable or cost too much. Native Hawaiians were also most likely to express the need for overnight respite, tax relief, and paid family leave. The findings highlight the importance of gender and culture in the way caregiving services and policies are offered.

Key Words

Native Hawaiians • male caregivers • service usage • public policy

INTRODUCTION

Recent research suggests a slight but notable increase in the percentage of male caregivers for older adults. The earliest surveys on this topic indicated that up to 80 percent of all care was provided by women (Aronson, 1992; Guberman, 1988; Hooyman, 1990). However, more current international research on caregiving has established that the percentage of male caregivers is on the rise (Arnsberger and Lum, 2007; Arnsberger et al, 2008; Hawai'i Department of Health, 2000).



Perhaps as a result, the past decade has seen an increase in research on male caregivers, exploring their patterns of caregiving and attempting to determine their special needs (Cahill, 2000; Milne and Hatzidimitriadou, 2003; Thompson, 2002). However, with some notable exceptions (Harris and Long, 1999; Li, 2004), the focus of research has largely been limited to Caucasian and African American caregivers with few samples including Asians or Pacific Islanders. Fortuitously, in one state in the nation, Hawai'i, the population distribution is quite different. This state has the second highest proportion of Asian Americans in the country and the highest percentage of Native Hawaiians and other Pacific Islanders (U.S. Census Bureau, 2009). Thus, it is possible to examine the roles of Native Hawaiian male caregivers of older adults in detail for the first time.

LITERATURE REVIEW AND BACKGROUND

MALE CAREGIVING

In the United States, the idea of egalitarian gender role expectations regarding child and elder care is generally endorsed, even if it is not played out in fact (Brewer, 2001; Smith, 2003), but the caregiving role may be enacted differently for men than for women. Some research implies that men will offer care from an emotionally safe distance, utilizing a problem solving approach to caregiving (Connell, 1995; Twigg and Atkin, 1994). Alternatively, other literature suggests that male caregivers are motivated by love, while women act out of duty (Mathew et al, 1990). Either way, male caregivers typically are called upon to meet a wide range of caregiving needs. Research indicates that men invest themselves in their caregiving role and provide quality and comprehensive care (Thompson, 2002), but the roles differ for sons and husbands (Archer and MacLean, 1993).

In general, spousal caregiving rests on the moral norm of reciprocity accompanied by genuine affection. The special nature of the spouse relationship, characterized by love and shared responsibilities, is offered frequently as the motivation for caregiving (Cahill, 2000; Miller and Kaufman, 1996). Husbands appear to accept caregiving as an extension of their marital vows and as part of the ongoing reciprocity between spouses (Milne and Hatzidimitriadou, 2003; Neufeld and Harrison, 1998). Research indicates that husbands who become caregivers have been open to altering household routines and learning basic household and caregiving skills usually associated with the feminine role (Hilton et al, 2000; McFarland and Sanders, 1999). However, caregiving husbands would like to receive more support than they actually do. The literature suggests that husbands prefer psycho-educational interventions and information that addresses specific caregiving problems (Almberg et al, 1998, McFarland and Sanders, 1999).

Son caregivers encounter different challenges in their caregiving careers. One frequently cited issue is work conflict. In 2004, 60 percent of male caregivers had to balance between full time job and caregiving responsibilities (AARP, 2009). Furthermore, they reported that companies did not understand or accept the increasing number of male caregivers because it violated social norms (AARP, 2009; Harris and Long, 1999). In some cases, younger male caregivers have to give up promotional opportunities because of their caregiving responsibilities, and older males sometimes take early retirement (Arnsberger and Lum, 2007; Harris and Long, 1999). Male caregivers who took an early retirement report that the workplace is not just a place to work, but also a resource for social support. As a result of their forced retirement, they experience social separation (Russell, 2004). Nonetheless when the need arises, employed sons often accept the caregiving role and frequently reduce their commitment to their employer (Hirsch, 1996).

Probably as a result of these issues, employed sons are more often considered to be secondary caregivers or part of a caregiving team, managing rather than providing most care (Belenky, 1997; Harris and Long, 1999). One study of caregiving sons indicates that bathing is one of the most difficult caregiving tasks to handle (Harris, 1998). However, this activity may not be as difficult for males from Pacific Islander cultures. In one study of Samoan caregivers in Hawai'i, there were no significant differences in caregiving patterns by gender. While a gender division of labor does exist among Samoans, it does not seem to extend to caregiving tasks. These data support other studies that note ethnic variations in caregiving patterns (Mui and Burnette, 1994; Tauiliili et al, 2001) and highlight the need for including cultural patterns in a discussion of gender issues in caregiving.

CAREGIVING IN THE PACIFIC BASIN

Hawai'i has a long tradition of family caregiving (Braun and Browne, 1998b; Mokuau, 1990; Browne et al, 2009). The Hawai'i Department of Health found that nearly 14 percent of all adults in the state identified themselves as caregivers. Furthermore, over 30 percent are male (Hawai'i Department of Health, 2000). Despite the fact that many Native Hawaiian and Pacific Islanders engage willingly in caregiving activities, they may not experience higher levels of well-being as a result. Pacific Islander caregivers appear to experience roughly the same levels of depression, burden and isolation as do caregivers of other races and on some levels (e.g. financial burden) often rate higher (AARP, 2001; Arnsberger et al., 2008). A sense of burden may also be heightened because of a tradition of filial obligation to provide care to older family members, demonstrating respect for the elder's worthiness and authority (Browne and Braun, 1998b).

Another area in which Hawaiian cultural values may affect the caregiving process is in service use. Caregivers from African American, Latino, Asian, and Pacific Islander populations consistently express higher levels of unmet social and mental health needs than do non-Hispanic white caregivers, as well as a greater need for formal support services (Aranda and Knight, 1997; Connell and Gibson, 1997). Nonetheless, this higher level of unmet need does not necessarily result in higher levels of service utilization. According to a literature review, existing evidence concerning disparities in service use among racial and ethnic groups is inconclusive. While most studies have reported a lower level of formal service utilization among minority caregivers compared to non-Hispanic white caregivers, others have reported higher levels of service use and some have found no differences (Scharlach et al, 2008). A recent study in California, one of the few to include Pacific Islanders in the sample, found that White and African American caregivers were twice as likely to use formal services as Asian, Native Hawaiian, Pacific Islander and Latina caregivers (Giunta et al, 2004).

A majority of studies that have exclusively focused on male caregivers, both quantitative and qualitative, use fairly small sample sizes, ranging from six to 100 male caregivers (Bookwala et al, 2002; Cahill, 2000; Harris, 1998). In addition, most studies are based on non-probability samples. Therefore, the generalizability of findings from these studies is limited. Finally, as noted above, few have the cell size to examine ethnic differences among male caregivers, especially for rarely occurring groups such as Native Hawaiians and Pacific Islanders. The purpose of the following study, therefore, is to use a probability sample of caregivers to compare the three major ethnic groups represented among male caregivers in Hawai'i. Specifically, the three research questions are as follows: How did the caregiving experience differ for males in the three ethnic groups in terms of who they were caring for and what they provided? Secondly, how did the groups differ on measures of caregiver burden and need to alter employment patterns? Finally, how did the groups differ on their use of services and preferences for government assistance?

METHODS

INSTRUMENT DEVELOPMENT

The original instrument utilized in the study was developed in 2001 by a team of gerontology researchers from the University of California at Berkeley and the University of California at San Francisco as part of a national data collection effort. This instrument was adapted for the Family Caregiver Support Project in 2007 for data collection in Hawai'i. The instrument contains 152 items and covers the following domains:

1. Caregiver and care recipient demographics, including gender, age, income, education, marital status, and current living arrangements (18 items);
2. Care recipient's activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments and chronic conditions (31 items);
3. Community service utilization patterns, reasons for not using services, and other services that might be useful (34 items);
4. Characteristics of the caregiving experience including tasks performed, paid and unpaid support for the primary caregiver, and length and intensity of caregiving (34 items);
5. Effects of caregiving including measures of physical, financial and mental stress as well as the cost of caregiving (5 items);
6. Employment related questions including the impact of caregiving on employment and benefits provided by employers (8 items);
7. Opinions about public policy options to support caregivers (22 items).

DATA COLLECTION

The study data were collected in the fall of 2007 and completed in January of 2008. Data were collected from a probability sample. Potential respondents were identified by random digit dialing. A total of 2,259 calls were needed to identify 600 caregivers who met the study criteria. A set of screening questions was used to identify eligible caregivers. These included a determination that (1) there was a caregiver for someone 60 or over in the household, (2) that at least some assistance with ADLs and or IADLs was needed by the care recipient, and (3) that the person providing care was unpaid. Oral consent was obtained over the phone. Oversampling of respondents occurred on neighbor islands in order to have the ability to make between county comparisons, but the data file was then weighted using county population estimates from the 2006 U.S. Census Bureau Projections for the State of Hawai'i. The sample size was 300 in O'ahu and 100 each in Hawai'i, Maui, and Kaua'i counties for a final sample of N=600. Of these, 27.3 percent, or 163, were male; however eight respondents had undetermined or missing ethnicity data. Therefore, 155 respondents comprised the sample used in the analysis.

DATA ANALYSIS

Data analysis was done in PASW© v18. Data were first examined for the independent variable of interest (ethnicity). Respondents were categorized into three ethnic groups – Native Hawaiians (24.2 percent), Caucasians (33.7 percent), and Asians (42.1 percent). The latter group included males of Japanese, Chinese, Filipino, Thai, mixed, and other Asian ancestries. The next step in the analysis was to establish codes for certain data fields. Several variables with multiple response categories were recoded as dichotomous in analysis. Marital status was recoded as 'married/partnered'

vs. all other responses, and living arrangement was recoded as 'live with caregiver' vs. all others, and 'lives alone' vs. all others. When describing the number of hours per week that care was provided, caregivers could select 'constant care.' That response was used to create a dichotomous variable in which constant care was contrasted with all other responses. In addition, two variables (income and the estimated annual cost of care) had significant percentages of missing data (31 percent and 20 percent respectively) and the decision was made to impute missing data using the nearest two median points.

An intent of the study was to predict service use by service category; however, only 115 respondents in the sample used any services at all and the remainder used an average of two. It was hypothesized from examination of the bivariate analysis that there may be a common factor underlying the use of any community services at all, regardless of type.

There was also significant overlap in the three separate burden scores (emotional, physical, and financial). A correlation matrix revealed that each type of burden was significantly correlated with the two others; therefore the hypothesis that a composite burden score would accurately reflect a generalized concept of burden was tested. The ordinally scaled burden items were subjected to scaling procedures (reliability analysis) in PASW v18. The range for each item was 1 (no burden) to 5 (intense burden). For the financial hardship item, the mean score on the item was 2.23 (sd 1.44). For physical strain, the mean score was 2.55 (sd 1.49), and for emotional stress, the mean score was 2.89 (sd 1.58). Scaling procedures produced a very acceptable Cronbach's alpha of .834. Therefore, a composite burden score was constructed based on the overall mean of the three measures.

Univariate analysis (frequencies for categorical variables and means, median, and measures of dispersion for continuous variables) provided the first results. All of the variables of interest were then subjected to bivariate statistical analysis (Chi Square tests of Association, Kruskal-Wallis Test and Analysis of Variance) to compare continuous (e.g. age, services used), nominal (e.g. did or did not require assistance with ADLs) or ordinal (e.g. financial, physical, and emotional burden) variables across the three ethnic groups. If significant, between group differences are reported. If not significant, then the results of the analysis are not reported (with the exception of descriptive demographic characteristics, including employment status, and summed service use).

RESULTS

There were several significant demographic differences between the male caregivers in the sample (see Table 1). Native Hawaiians were significantly younger than the other two groups, had the lowest level of education, lowest household income, and on average were caring for more individuals. Along with Asian males, they were far less likely to be caring for a spouse. In addition, they had the highest percentage of care recipients in a nursing home setting.

TABLE 1: MALE CAREGIVERS IN HAWAI'I (N=155).

Variable means or percentages	Caucasian N=50	Asian N=62*	Nat Haw N=36	P<.05
Caregiver age	59.96	58.51	52.4	.017 (NH/Asian) .038 (NH/Caucasian)
CR is spouse or partner	30.6%	12.7%	11.1%	.023
CR is parent	46.0%	50.8%	61.1%	NS
CR is other relative or friend	22.4%	36.5%	27.8%	NS
Number of people cared for (mean)	1.23	1.16	1.52	.038 (NH/Caucasian) .008 (NH/Asian)
CR current living arrangement				NS
Alone	38.0%	40.3%	52.8%	
W/caregiver	28.0%	30.6%	19.4%	
With spouse/prtnr	4.0%	1.6%	0%	
In home of friend/rel	26.0%	22.6%	8.3%	
In retirement home	4.0%	0%	8.3%	
In nursing home	0%	4.8%	11.1%	
Number of children to care for under age 18 (among those with children)	1.29	2.21	2.13	.044 (Asian/Caucasian)
Length of time in Hawai'i	25.34	32.53	26.71	NS
Caregiver educational level ¹	4.99	4.53	3.59	.001 (NH/Caucasian) .025 (NH/Asian)
Caregiver total household income ²	6.75	5.61	3.77	.0001 (NH/Caucasian) .019 (NH/Asian)
Est annual cost of caregiving ³	2.52	2.71	2.08	.055 (NH/Asian)

*Includes Chinese, Japanese, Filipino, Thai, mixed, and other Asians.

¹Coded as 1<HS; 2=HS grad; 3=some com coll; 4=com coll grad; 5=some 4 yr college; 6=Bachelor's Degree

²Coded as 1<\$20,000; 2=\$20–24,999; 3=\$25–25,000; 4=\$30–34,999; 5=\$35–39,999; 6=\$40–44,999; 7=\$45–49,999

³Coded as 1<\$1,999; 2=\$2,000–4,999; 3=\$5,000–9,999

Table 2 reports only significant differences between groups on characteristics of the caregiving process. Having someone able to assist if the respondent was unable to provide care was reported by a higher percentage of Native Hawaiians as compared to Caucasians and Asians. They had also been caregiving for the longest length of time (approaching 5 years) but had the lowest levels of sleep deprivation.

TABLE 2: CHARACTERISTICS OF CAREGIVING EXPERIENCE BY ETHNICITY

Variable	Caucasian	Asian	Native Hawaiian	Asymp. sig/between group differences
If unable to help is there someone else to assist	66.0%	67.8%	88.9%	.038
CG provides constant care	18.0%	42.9%	25.0%	.012
Sleep been interrupted as a result of caregiving	27.7%	33.9%	11.1%	.046
Length of caregiving career ¹	3.1	3.56	3.88	.033 Asian/Caucasian .002 NH/Caucasian
Travel time ²	2.64	1.73	2.04	.041 NH/Caucasian .001 Asian/Caucasian

No significant difference on number of hours other family members provide care; constant care provided by other family members; number of hours per week caregiver produced care or caregiver provides most care himself.

¹Coded as 1=<6 mo's; 2=6–12 mo's; 3=1–5 years; 4=6–10 years

²Coded as 1= live together; 2=less than 15 minutes; 3=16–30 minutes

TABLE 3: SIGNIFICANT DIFFERENCES IN PROVIDING ASSISTANCE BY ETHNICITY

Variable CR requires help with	Caucasian	Asian	Native Hawaiian	Significance level
Dressing eating bathing Respondent helps	60% 53.5%	62.9% 78.9%	61.1% 77.3%	NS .004
Financial matters Respondent helps	68.0% 64.7%	75.8% 54.2%	41.7% 40%	.0013 .038
Shopping Respondent helps	78.0% 76.3%	77.8% 73.5%	75.0% 55.6%	NS .001
Preparing meals Respondent helps	76.0% 51.4%	98.4% 67.2%	63.9% 47.8%	.0001 .008

No significant difference in assistance with medical needs; arranging for care.

Table 3 shows significant differences on either ADL or IADL impairments. If there was not a significant difference in the level of impairment but there was a significant difference in whether or not the respondent was the person who provided that care, this was also reported in the table. Caucasian and Asian males were significantly more likely to provide assistance with shopping and financial matters as compared to the Native Hawaiian respondents. On the other hand, Native Hawaiian and Asian males were both significantly more likely to help with personal care than were the Caucasian males.

Table 4 shows significance differences between on the care recipients' chronic conditions. Here, Native Hawaiian care recipients had significantly lower percentages of hypertension and coronary artery disease, but were much higher on diabetes and severe vision difficulties.

TABLE 4: SIGNIFICANT DIFFERENCES IN CHRONIC CONDITIONS BY ETHNICITY

Variable	Caucasian	Asian	Native Hawaiian	Asymp. Sig.
Hypertension coronary artery disease	70%	67.7%	42.4%	.022
Diabetes	8%	29.3%	59.3%	.0001
Hearing impairment	22.0%	47.6%	27.3%	.011
Severe visual impairment	24.0%	4.8%	48.5%	.0001
Chronic obstructive lung disease	28.0%	9.5%	30.3%	.016
Severe memory problems	36.0%	56.5%	18.5%	.052

No differences in arthritis; cancer; CVA/Stroke; HIV/AIDS; mental health problems; behavior problems.

Table 5 shows the employed caregivers. There were no significant differences in the percentage of those employed by ethnicity or in the percentage that experienced difficulties at work. Among those who did experience difficulties at work, Native Hawaiians reported the highest rates of turning down promotion and shared with Caucasians the need to change work schedules.

Table 6 reports on the 'inclination to use community services' scale. There was not a significant difference between groups. Across the board, Caucasians used the fewest services. Native Hawaiians were most likely to use training services and transportation. As so few caregivers use services, it becomes important to look at the reasons for non-service use (see Table 7). For Native Hawaiians, the highest endorsed reasons for non-service use were that services were not available or they cost too much.

TABLE 5: EFFECT ON EMPLOYMENT BY ETHNICITY

Variable	Caucasian	Asian	Native Hawaiian	Asymp. Sig.
Currently employed ¹	52%	56%	44.4%	NS
Of those currently employed: % whose work affected by caregiving ²	41.4%	21.1%	24.0%	NS
Of those whose work affected by caregiving:				
(a) Lacked concentration	50%	5%	0%	.011
(b) Rearranged work schedule	100%	62.5%	100%	.022
(c) Exper schedule difficulties	50%	100%	66.7%	.059
(d) Exper difficulty w/ mngmnt	0%	71.4%	66.7%	.001
(e) Took unpaid leave absence	25%	71.4%	0%	.017
(f) Turned down promotion	50%	0%	66.7%	.021

¹Of those who were employed, 98.4% were employed full time; therefore no separate analyses were done for PT employees.

²There were no significant differences between ethnicities on arriving late or leaving early; taking early retirement, doing personal business during work hours, giving up work altogether, missing appointments, experiencing co-worker resentment, exp work day crisis interruptions, took 2nd or 3rd job, changed jobs.

TABLE 6: SERVICE UTILIZATION ¹ (N=119)

Variable	Caucasian	Asian	Native Hawaiian	Asymp. Sig.
Mean number of services used	2.08	2.40	2.03	NS
Adult day care	12.0%	25.8%	0%	.003
Transportation	20.0%	19.0%	52.8%	.001
Bathing/personal care	12.0%	28.6%	0%	.001
Assigned case manager	6.0%	23.8%	9.7%	.020
Training services	12.0%	15.9%	36.1%	.013
Number of hrs per week by paid service providers (N=15)	5.00	9.33	6.67	.001 Asian/ Caucasian

¹No significant difference in terms of Meals on Wheels, counseling, nursing services, cleaning, shopping, cooking, heavy cleaning, yard work, companion, health maintenance services, legal services, financial services, end of life services.

TABLE 7: REASONS FOR NON SERVICES UTILIZATION

Variable	Caucasian	Asian	Native Hawaiian	Asymp. Sig.
CR does not want	41.2%	56.3%	7.7%	.024
Services not available	0%	0%	50%	.005
No one to stay when help	60%	0%	23%	.007
Services cost too much	42.9%	9.1%	57.1%	.046

No significant difference in terms of already have enough help; service quality is poor; providers don't speak our language; no time to get help; help not available at the times I need it; transportation not available; services not offered by people like me; long waiting list.

TABLE 8: EMOTIONAL FINANCIAL AND PHYSICAL EFFECTS OF CAREGIVING

Variable (means)	Caucasian	Asian	Native Hawaiian	Significance Level
How much of a financial hardship ¹	2.05	2.34	2.13	NS
How much of a physical strain ¹	2.33	2.63	2.35	NS
How emotionally stressful ¹	2.76	3.04	2.44	.054 (NH & Asian)
CG burden composite score	7.14	7.92	6.93	NS

¹Coded 1= no hardship to 5= a great deal of hardship

TABLE 9: GOVERNMENT RECOMMENDATIONS: SIGNIFICANT DIFFERENCES BY ETHNICITY*

Question: The government should provide:	Caucasian	Asian	Native Hawaiian	Asymp.sig
Overnight respite	33.3%	64.4%	69.7%	.001
State income tax credit for caregiving	80.9%	85.5%	100%	.034
Paid family leave program	61.0%	79.0%	87.9%	.019
Training and education	63.8%	83.6%	78.8%	.053
Unpaid family leave	63.3%	100%	83.3%	.005

*No between group differences were found in the following items: place to get information and support; daytime respite; weekend respite; allowance to family members; case management services; availability of community services; affordability of community services; state income tax credit for LTC insurance.

Table 8 shows the emotional, financial, and physical effects of caregiving. On the composite burden score, Native Hawaiians were the lowest of the three groups. In one category (emotional burden), this was a significant difference.

Table 9 shows how questions about government policy and programs vary by ethnicity. Native Hawaiians were the strongest endorsers of all government programs except for training and education and unpaid family leave.

DISCUSSION

This study highlights the importance of the consideration of both gender and cultural issues in family caregiving. Understanding of a 'gendered' point of view and a particular cultural or ethnic tradition is essential for both clinical and research questions because these values around caregiving affect caregiving outcomes (Aranda and Knight, 1997; Giunta et al, 2004; Tauiliili et al, 2001). Several examples of the utility of employing this combined viewpoint are contained in our findings.

First, Native Hawaiian caregiving males are at a disadvantaged position at the beginning of their caregiving careers, with significantly lower levels of education and income than their Caucasian and Asian counterparts. In addition, they care for more people on average and have longer caregiving careers than the other two ethnic groups represented in this study. Native Hawaiians have difficulty getting access to needed services and would use more if they could afford them. The lack of access to affordable services could also explain why Native Hawaiians are overrepresented in the nursing home population. Medicaid (for which 40 percent of our sample reported they were eligible) will pay for 24-hour care when it is in a facility, but is limited in coverage if the older adult remains in the community. Finally, Native Hawaiian respondents reported a higher percentage of care recipients with diabetes than the other two groups. This reflects the fact that among ethnic groups in Hawai'i, Native Hawaiians have the highest rates of diabetes (10.3 percent) (Hawai'i Department of Health, 2008).

On the positive side, Native Hawaiian male caregivers report they have the highest available levels of informal assistance, the lowest levels of sleep deprivation and also experience the lowest levels of burden. They are far more likely to be caring for a parent or other relative than a spouse and are the least likely to live with the care recipient. Nonetheless, they would like more support from the government in terms of both services and policies that would support their efforts, including overnight respite, tax relief, and a paid family leave policy. As many of the Native Hawaiian caregivers are employed sons and have a relatively low income, endorsement of these policies is not surprising.

Ethnicity and country of origin will also impact service use through differential cultural norms regarding family responsibility and the acceptability of utilizing extrafamilial support services (Scharlach et al, 2008). While our findings support

those of other researchers that male caregivers are likely to access formal services (Cahill, 2000; Coe and Neufeld, 1999; Kaye et al, 2008; Stoller and Cutler, 1992; Zarit et al, 1986), we also found that two groups of our male caregivers, Asian and Native Hawaiian caregivers specifically, also provided personal care (bathing, feeding, etc.) themselves. This is especially surprising given that the majority of these caregivers were sons, not husbands. Thus, the findings from this study highlight the importance of consideration of both gender and culture in the way caregiving support is offered and provided. It was also found that “caregiving patterns and service utilization among API (Asian Pacific Islander) minorities are influenced by a variety of factors, including cultural values and traditions, length of time in the United States, educational attainment, economics, discrimination, perceptions of services, and changing needs of both caregiver and elder.” (Braun and Browne, 1998a).

This study also validates the work of other researchers who found that there are differential levels of caregiving stress and methods of coping with it among cultures (Brewer, 2001; Harris and Long, 1999; Janevic and Connell, 2001). Even with the disadvantage of limited resources, Native Hawaiian males were less burdened by the caregiving experience than their Asian and Caucasian counterparts. While it is beyond the scope of this research to explain why this is the case, one possibility is suggested in a recent article on the resiliency of Native Hawaiian elders. The authors note that in spite of (or perhaps because of) a history of discrimination, internalized racism, and poor health indicators, there still exists a resilient culture with an enduring commitment to family (ohana) care (Browne et al, 2009). We would suggest that it is this sense of resiliency combined with the tradition of kupuna (elder) care that sustains the Native Hawaiian male caregiver through the difficult challenges of providing spousal or parental care. In addition, in traditional Hawaiian culture, there is also a tendency to accept chronic health conditions and adjust to their consequences without complaint. Throughout Hawaiian history, the unpredictability of good health was integrated with traditional Hawaiian religious beliefs which emphasized the harmony of life and importance of maintaining a sense of balance between the individual, his or her family and environment (Mokuau, 1990). In addition, caregiving itself is regarded with spiritual significance and importance which lends meaning to the caregiving process (Braun and Browne, 1998b). The low level of burden found among Native Hawaiian male caregivers in this study could be part of that process of finding meaning in the acceptance of life’s problems and dealing with them with equanimity. Native Hawaiian male caregivers also received more informal help than other male caregivers in the study, which has been noted as one of the better predictors of stress reduction in other studies, including several in the Pacific Rim region (Arnsberger et al., 2008; Portero, 2007). In this culture, research has shown that families traditionally

work together, allocating tasks to provide care for sick or disabled members, “Within traditional Hawaiian families, each member had his or her kuleana [role]; these roles were very explicit and based on age, gender, class, and ability” (Braun and Browne, 1998a, p.173). One of the goals of service provision for this culture would then be to supplement and support ongoing family care with community based services, rather than replace it with institutional care.

One advantage of this study was that the sample enabled the authors to clearly differentiate between male caregivers of Asian and Native Hawaiian ethnicity. These two groups, often lumped together in analysis, when separated, share both similarities and differences in their approaches to caregiving. For Native Hawaiians as well as Asians, family is an important unit for caregiving. In both cultures there are expectations to care for elders at home by the extended family (ohana in Hawaiian). But Hawaiian culture is very unique and has distinctive traditional ways to heal illnesses, such as the use of a Hawaiian healer or using methods such as ho’oponopono that require the restoration of justice before a family can resolve its problems (Braun et al, 2004). Therefore, providing culturally appropriate services is essential for Native Hawaiians. Braun and Browne (1998a) suggested that the most acceptable services for Native Hawaiians were homemaker and transportation services because elders stay at home and services are delivered to their homes. Our results supported this conclusion. On the other hand, this study found that services such as offsite or center based day care are less favorable for Native Hawaiians, but more likely to be used by Asian male caregivers. This finding highlights how crucial it is to include ethnic and cultural preferences in the mode of service delivery.

Overall there are differences between Native Hawaiians and the other two groups in our study in terms of caregiving patterns, but among male caregivers these are shifted slightly and are affected by gender. In particular, support for son caregivers who are caring for parents and are employed, emerges as one of the themes that needs to be addressed. The availability of income support in the form of a paid family leave program would be especially crucial for the well-being of Native Hawaiian male caregivers. Another policy initiative is needed to increase the effective use of the formal care system in order to prevent unnecessary or premature institutionalization. The high rate of institutionalization among Native Hawaiians in this study, along with their expressed inability to access and afford needed services, is a distressing result of the lack of such a policy and needs to be addressed in the very near future. On the research front, we need more caregiving studies among Native Hawaiian and Pacific Islanders (there are, for instance, virtually no studies on caregiving in Samoan and Tongan cultures) as well as studies that focus on policies and services that can assist the dedicated and determined male caregivers in this community.

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