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Association of Filial Responsibility, Ethnicity, and Acculturation Among Japanese American Family Caregivers of Older Adults

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Abstract

Challenges of filial caregiving practices by 1st-generation immigrants due to differences in caregiving values between their home and host countries are well documented. This study explored the filial responsibility of later generation Japanese American caregivers of older adults. Acculturation and filial responsibility were measured using the Suinn-Lew Asian Self Identity Acculturation scale and Filial Values Index, respectively. A qualitative interview guide was developed using Gordon's assimilation theory, and 21 caregivers (*M*age = 68 years, 86% female, seven in each generation) were interviewed. Despite the 3rd-generation caregivers' high acculturation level, their filial responsibility scores remained high. Qualitative interviews also revealed later generation caregivers' strong filial responsibility and continued caregiving involvement. Unexpectedly, caregivers' own future expectancy of care included placement in mainstream residential facilities rather than ethnicspecific settings. Findings point to the need to develop caregiver services that consider later generation caregivers' culture and level of assimilation.

Keywords

assimilation; culture; filial responsibility; Japanese American; later generation caregivers

With the growing diversity in the aging population and their caregivers, researchers are turning attention to the racial, ethnic, and cultural differences in caregiving patterns and caregivers' needs. Early studies focused on Black, Hispanic, and non-Hispanic White caregivers (Connell & Gibson, 1997; Dilworth-Anderson, Williams, & Gibson, 2002; Janevic & Connell, 2001). More recent studies address variations between and within Asian and Hispanic caregivers, including sub-ethnic groups (Aranda, Villa, Trejo, Ramírez, & Ranney, 2003; Kong, 2007; Mokuau & Tomioka, 2010; Sun, Ong, & Burnette, 2012). Caregiving challenges resulting from Asian and Hispanic immigration patterns and cultural differences between home and host countries are discussed (Crist & Speaks, 2011; Kong, Deatrck, & Evans, 2010; Zhan, 2004).

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These studies primarily addressed 1st-generation immigrant caregivers who are likely to have unique caregiving challenges related to adjustments to a new country, a new language, and cultural differences. In contrast, U.S.-born 2nd-, 2.5-, and 3rd-generation caregivers likely have English as their native language, a U.S. education, and tend to be familiar with U.S. health care systems. Because these later generation caregivers have grown up as Americans, their level of filial responsibility may differ from that of 1st generation caregivers (Funk, Chappell, & Liu, 2013; Hsueh, Hu, & Clarke-Ekong, 2008; Kao, Lynn, & Crist, 2013).

Previous studies have hypothesized that later generation caregivers may be less involved caregivers than earlier generations because of assimilation to the more individualized U.S. culture (Ho, Friedland, Rappolt, & Noh, 2003; Rudolph, Cornelius-White, & Quintana, 2005). Supporting this hypothesis are studies that have found behavioral changes, such as less frequent contact and less likelihood to live nearby, between 1st and later generations of Asian (Ishii-Kuntz, 1997) and Hispanic caregivers (Rudolph, Chavez, Quintana, & Salinas, 2011; Rudolph et al., 2005). Subsequently, some researchers have raised questions about the needs of the next generations of caregivers and how these may differ from past generations (Anngela-Cole & Hilton, 2009; Kobayashi & Funk, 2010).

To determine needs and extent of filial responsibility, 21 face-to-face interviews were conducted with 2nd-, 2.5-, and 3rd-generation Japanese American family caregivers of older adults. They were chosen because they are one of the largest Asian sub-ethnic groups and have the longest immigrant history in the United States among Asian groups. Therefore, their current caregivers are more likely to belong to 2nd, 2.5, and 3rd generations. The 2nd-generation caregivers were either born in the United States or immigrated before age 14, and their parents were born elsewhere. The 2.5-generation caregivers were born in the United States with U.S.-born parents (*Nisei*) who were educated in Japan and later returned to the United States (*Kibei Nisei*). The 3rd generation (*Sansei*) were U.S.-born caregivers whose parents were also U.S.-born.

Literature Review

A large number of Japanese immigrants, primarily single male laborers, arrived in Hawaii in late 1880s due to the severe economic conditions in Japan. The labor needs on the Hawaiian sugar plantations and the loss of cheap immigrant laborers exacerbated by the Chinese Exclusion Act of 1882 brought Japanese males and their wives to Hawaii (Saiki, 1985). Mainland Japanese immigrants, in contrast, were single males or men who left their wives in Japan. The influx of Chinese immigrants during the California Gold Rush in the mid-1840s heightened anti-Asian sentiment on the west coast. Japanese immigrants became a new threat to White American society, leading to the 1907 Gentlemen's Agreement between Japan and the United States that stopped Japanese migration to the United States. Because anti-miscegenation laws prohibited Japanese men from marrying White women, they arranged picture brides (Kessler, 1993). This resulted in Japanese American enclaves with U.S.-born 2nd-generation children (Akiba, 2006). Some of 2nd-generation children spent their education years in Japan and later returned to the United States as adults (*Kibei Nisei*). They spoke Japanese as their first language, were raised by their grandparents, learned

Japanese traditional virtues (Kitano, 1993), and attained Japanese identity (Hikoyeda, Mukoyama, Liou, & Masterson, 2006).

With improved socioeconomic conditions in Japan, a low birth rate, and a high out-marriage rate, the Japanese American population has been relatively stable since the 1960s. In 1970, Japanese Americans were the largest Asian U.S. group, but by 2000, they were the smallest. Because the majority of Japanese Americans belong to 3rd and later generations, they are the Asian group most assimilated into American society (Akiba, 2006). This assimilation pattern is reflected in caregiving practices among Japanese American caregivers. Filial piety is a fundamental Confucian value emphasized in Japanese culture. Adult children are expected to sacrifice their physical, financial, and social needs for the benefits of their parents, and take a family-centered approach to fulfill their filial responsibility (Dai & Dimond, 1998). Although they perform their caregiving duties, they often use outside professional help, which is counter to traditional Asian caregiving beliefs (Young, McCormick, & Vitaliano, 2002a, 2002b). Some 2nd- and 3rd-generation caregivers report that the stronger the Asian cultural values, the higher the level of caregiving burden (Knight et al., 2002).

Theoretical Framework

The theoretical framework for this study is Gordon's (1964) classical assimilation theory, which posits that the longer immigrants reside in the host society (the later the generation), the greater the assimilation and similarities between the immigrant and majority groups. Gordon theorized seven stages: (1) cultural/behavioral (acculturation), (2) structural, (3) marital, (4) identificational, (5) attitude-receptional, (6) behavior-receptional, and (7) civic assimilation. This study focuses on Stages 1 (i.e., acculturation) and 4 (i.e., identification) among later generation Japanese American caregivers.

Study Purpose

The purpose of this study was to determine needs and measures of acculturation and filial responsibility by generational level among Japanese American caregivers. The aims and hypotheses were as follows:

Aim 1: To examine the level of filial responsibility among 2nd-, 2.5-, and 3rd-generation caregivers as measured by acculturation and filial values scales.

Hypothesis 1: Second-generation caregivers have a higher level of a sense of filial responsibility compared with that of 2.5- and 3rd-generation caregivers.

Aim 2: To explore in depth the caregiving attitudes and needs of 2nd-, 2.5-, and 3rd-generation caregivers.

Method

Measures

The first 21 questions out of the 26-item Suinn-Lew Asian Self Identity Acculturation (SL-ASIA) scale (Suinn, 1994) were used to measure Japanese American caregivers' level of acculturation (1 = *low acculturation*, 3 = *bicultural*, 5 = *high acculturation*). It is the most

often used acculturation scale for Asian Americans (Miller & Speight, 2006) across age groups 18 to 87 years (Ownbey & Horridge, 1998). The 12-item Filial Values Index (Jones, Lee, & Zhang, 2011) measured the levels of filial responsibility, care, and respect of adult children toward parents (1–4 = *disagree*, 5 = *neither disagree nor agree*, 6–9 = *agree*), and has been successfully tested for caregivers across five cultural groups including Japanese Americans. These scales were used to quantify the level of acculturation and filial values of each caregiver and of the generation cohorts as a whole.

The qualitative part of the study explored in more depth caregivers' levels of acculturation and filial responsibility. An interview guide was developed based on literature reviews on Asian American caregivers (Miyawaki, 2015) and Stages 1 (acculturation) and 4 (identification) of Gordon's theory. Specifically, stages of acculturation and identification informed interview questions regarding the dimensions of caregiving, cultural values, and acculturation. For example, the acculturation stage led to questions such as, "Have you experienced any caregiving challenges/conflicts specifically in relation to you and your loved one's generational differences?" The identification stage was appraised with the question, "Although you were born in the U.S., have you experienced any challenges adjusting to Western culture in terms of your caregiving practices?" The questions used to measure filial responsibility were, "What are the primary reasons you are providing care? [Probe: Do you do so because you want to do it, you are the only one available or you feel responsible to care for your loved one?]" and "How do you think about your sense of filial responsibility?"

Interview questions were pilot-tested with two Japanese American caregivers from different generations, and a few modifications were made. The final version had 17 semi-structured questions covering six themes: (a) demographic information; (b) dimensions of caregiving; (c) cultural values; (d) acculturation; (e) intervention, program development, policy changes; and (f) recommendations for future caregivers. These questions were incorporated into the acculturation and cultural values themes, respectively.

Study Recruitment and Data Collection

Inclusion criteria were caregivers' immigrant generation (2nd, 2.5, 3rd), relationship between caregiver and care recipient (child/parent, etc.), and types and length of care (minimum of 6 months). Caregiving was defined as providing assistance in care recipient's activities of daily living (ADLs; for example, bathing, walking, feeding) and instrumental activities of daily living (IADLs; for example, doctor's appointment, giving rides).

Recruitment strategies started with contacting major ethnic-specific senior facilities, churches, and community organizations. Key contacts from these organizations, study advertisement fliers, snowball sampling (asking those referred to refer others), and referrals from ethnic-specific community agencies were then utilized. Interested persons were instructed to contact the study's principal investigator (PI; C.M.) via phone or email. Because this was part of a larger study, recruitment was stratified, and seven caregivers for each generation group were deemed to be a fair sample size to achieve theoretical saturation and representation.

Eligibility was verified during the first phone or email contact, and those who were eligible and remained interested were scheduled for an interview at a mutually agreed location. Participants were sent a study packet that included the SL-ASIA scale and Filial Values Index to complete prior to the interview. Face-to-face interviews were conducted to explore Japanese American caregivers' sense of filial responsibility. Semi-structured interviews allowed more in-depth and nuanced data compared with quantitative studies of Japanese American caregivers. Informed consent was obtained, and all interviews were conducted by the PI (CM) between July and October 2013 and, with permission (all agreed), were digitally recorded. Participants were compensated US\$20. The study was approved by the University of Washington Institutional Review Board.

Analysis

The SL-ASIA scale scores were calculated as the average of the first 21 questions. Sub-scores of the responsibility, respect, and care scales (four items each) from the Filial Values Index were calculated as the average of item responses. The mean score by generation was computed as the average for participants in each generation.

Recorded interviews were professionally transcribed verbatim. Transcriptions were entered, coded, and analyzed by the PI (CM) using Atlas.ti7. General impression and participants' facial/verbal expression were recorded in memos immediately after each interview. The analysis was done through an ongoing process of comparing between and within transcripts and memos by participants and generations. Inductive content analysis (Elo & Kyngäs, 2008) was used because of the limited knowledge about the acculturation and filial responsibility among later generation Japanese American caregivers. First, broad themes (e.g., dimension of caregiving, cultural values) elicited by the interview questions were identified and coded. Next, as axial coding, passages with similar content were grouped, and sub-themes were developed that reflected more situational perspectives (e.g., type of assistance provided, caregiving challenges, coping strategies within the dimension of caregiving theme; Table 1). These sub-themes consisted of similarities and differences between and within participants and generations (Charmaz, 2006). Sub-themes were redefined throughout the process until theoretical saturation was achieved in each generation group of caregivers. Several steps were taken to enhance analytic rigor and to reduce interpretation biases. The PI received written and oral feedback about the interview guide and the study results from four University of Washington faculty members who were experts in qualitative research and in the field of caregiving (Charmaz, 2006; Lincoln & Guba, 1985). A senior faculty (NH) read six transcripts independently and checked all the codes under both themes and subthemes that the PI recorded, and no changes were made. Furthermore, for accuracy of data interpretation and validation purposes (credibility), member checking (Turner & Coen, 2008) was also conducted by a total of six participants, two in each generation. These six interview transcripts were different from the six reviewed by the senior faculty. These activities led to greater clarity of interpretation and analyses of interviews, and reviews continued until these experts were all in agreement.

Results

Participants' Characteristics

A total of 28 people contacted the PI about potential study participation. All were contacted by PI, determined to be eligible, and agreed to participate in the study. Among them, three were placed on a wait list (one 2nd and two 3rd generation) because there were enough number of participants in these generations. Four could not participate due to inability to find mutually agreeable times and locations. Interviews were conducted with 21 family caregivers who met study criteria and lived within the Seattle metropolitan area. The interviews ranged from 1 to 2 hr.

The majority of participants were college educated (67%), married (86%), working (81%), female (86%), and age ranged from 54 to 90 years ($M = 67.8$ years, $SD = 10.96$ years; Table 2). Second-generation caregivers were on average 10 years older than 2.5- or 3rd-generation caregivers. Care recipients were mothers (74%) and fathers (26%) and level of ongoing care varied by generation (2nd: 29%; 2.5: 75%; 3rd: 50%; Table 3). Second-generation caregivers were least likely to live with care recipients (28.6%) compared with other generations (2.5: 57.1%; 3rd: 42.9%). Second generation did not use professional caregivers, while 30% to 45% of 2.5 and 3rd generations utilized professionals. More than 50% (2nd and 3rd: 2.5: 75%) placed their loved ones in residential facilities. Second-generation caregivers cared the longest ($M = 16.0$, $SD = 11.29$) whereas 3rd generation the shortest ($M = 9.2$, $SD = 7.71$), and the caregiving duration before institutionalization followed the same pattern: the later the generation, the shorter caregiving duration.

Acculturation Level of Participants (Aim 1)

The SL-ASIA scale measured the acculturation level by spoken/written-language, and ethnic identification of parents, race/ethnicity of friends/peers, residential community, and food preference. Caregivers' acculturation level was in the expected direction: the later the generation, the higher the level of acculturation (Table 4).

Filial Value Level of Participants (Aim 1)

There were three filial values scales: responsibility, care, and respect (Table 4). Out of nine score levels, the majority rated high in each score in all scales. There was a clear pattern across generation in all three scales. While 2nd-generation caregivers showed the highest scores in responsibility and care scales, 2.5-generation caregivers indicated the lowest scores. In terms of respect, both 2nd- ($M = 8.3$, $SD = 0.70$) and 2.5- ($M = 8.3$, $SD = 0.68$) generation caregivers were slightly lower than 3rd-generation counterparts, scoring 8.5 ($SD = 0.38$).

Caregiving Attitudes and Needs (Aim 2)

Theme 1: Dimension of caregiving—Five subthemes emerged within this theme: (a) type of assistance provided, (b) caregiving challenges, (c) coping strategies, (d) informal, and (e) formal support.

Types of assistance provided: The majority of assistance focused on IADLs (84%), with transportation most prevalent, followed by cooking/meal preparation, shopping, and finances. Assistance with ADLs included bathing, walking, dressing/undressing, feeding, and toileting. Third-generation caregivers helped the most compared with other generations in both ADLs (7 cases) and IADLs (20 cases), while none of the 2.5 generation assisted with ADLs. Second- and 2.5-generation caregivers assisted with English translation and interpretations and driving (nine cases). As noted by a 2.5-generation daughter, “I think I always help my mother and father [because they couldn’t drive and speak English].” In addition, culturally related communication patterns with authority figures arose:

Once I took drivers’ license, I drove ... my Mom to most of her doctors’ appointments. I like to go into the doctors because I think how her upbringing and the culture, not very direct with authority figures. So you have to kind of be there to tell them because she won’t tell them directly, so I have to tell them. (2nd-generation daughter)

Greatest caregiving challenges: The greatest caregiving challenges were emotional stress, lack of available help, and maintaining a balance of life. Caregiver’s emotional stress was the most frequent challenge across generations because of care recipients’ unreasonable comments/criticism toward caregiver. For example, a 3rd-generation daughter expressed,

How hard it is to take care of physical, but that’s not the hard part, it’s that the mental part because ... getting blamed for everything [from the care recipient] and that person being angry when you are trying to help them. That’s the hard part.

Juggling multiple tasks and balancing caregivers’ lives were also frequently expressed concerns. Because caregivers are always on the go to manage their responsibilities, a 2.5-generation daughter told herself, “You got a slow down here.” One 2.5-generation daughter realized that “You can’t always be the one saying yes, yes. You’ve got to take care of yourself, so you have to sometimes say—I am sorry. I can’t do that.”

Coping strategies: Coping strategies varied across generations from talking with their family and friends (all generations, 38%), sports/exercise (2.5: 13%), traveling, and work (keep them busy with something else). However, 2nd (three caregivers) and 2.5 (two caregivers) generations had no coping strategies because caregiving was something expected:

Coping strategy? It [Caregiving] was just natural that I have to take care of my parents. (2nd-generation son)

It [Caregiving] was just given. (2nd-generation daughter)

There was no question that what I did I wanted to do and I needed to do ... I didn’t question it. It had to be done. (2.5-generation daughter)

Informal support: All caregivers primarily relied on siblings to share responsibilities. As one 3rd-generation daughter said, “My brother and myself and younger sister made out a schedule and we came down Friday [after work] and Saturday and went home Sunday.”

A clear pattern in informal support systems emerged. Three caregivers had no siblings and seven caregivers' siblings (39%) lived out of state (2nd: 3; 2.5 and 3rd: 2). Three 2nd-generation caregivers whose siblings were not locally available relied on spousal help:

My husband is very helpful which really helped, and my mom loved him which helped ... mom would get up in the middle of the night [but] she wasn't able to get up, so my husband and I would take turns sleeping there overnight. (2nd-generation daughter)

The 2.5- and 3rd-generation caregivers with out-of-state siblings not only used spousal support but also placed their care recipients in either assisted living or skilled nursing facilities.

Formal support: Most families did not hire paid caregivers but instead chose to place their loved ones in long-term care facilities. Care recipients, although initially unhappy, were also receptive to such placement across generations:

She was a little resistant at first, but not very much. She knew she was having trouble cooking and cleaning and that kind of stuff so (2.5-generation son)

She wasn't real happy. She said you mean forever? I'll be here like a prison? ... I said well, let's try out for a while ... Yeah, she says, Oh, OK ... [then after a while] she LOVED it. She had the *Nihonshoku* [Japanese food at the facility]. (3rd-generation daughter)

Theme 2: Cultural values—Cultural values consist of sub-themes: (a) sense of filial responsibility and (b) familism.

Sense of filial responsibility: Regardless of generation, all caregivers expressed a strong sense of, and demonstrated some forms of, filial responsibility in accordance with Asian cultural tradition and expectations. This traditional thinking, especially for the oldest son or daughter among siblings and as a woman in the family, seems to continue among later generation caregivers. As noted by two 2.5-generation daughters: "[Being the oldest daughter] I think that was just expected" and "I felt no resentment ... this is something that you do because they are your parents, and they took care of you. Now it's your turn to take care of them." Similarly, a 2nd-generation daughter never questioned her responsibility: "I felt like that's what I was supposed to do ... you wanted to do it, too." A 3rd-generation son said, "It comes down to that I am the oldest. That's a given ... they sacrificed a lot ... I am committed ... it's just way of life. I would do it again, no regrets" and a 3rd-generation daughter said, "I owe it to them [parents] because they gave to me. They kept giving, giving, giving you know ... it's my turn" and

I value what my parents have done for me ... we feel a sense of responsibility, a sense of obligation to our parents because they were so good to us. I would do it. I didn't look at it as a burden.

Familism: Within the Asian cultural value of familism (e.g., family's welfare is considered over that of individuals), elders are well respected. Not bringing shame to the family's name,

and face in the community, are emphasized in children's behaviors, and personal matters are to be kept private within the family (Lee & Choi, 2013). Two 2.5- and one 3rd-generation caregivers have never heard the term *familism*, but the vast majority have heard a concept while growing up. Nonetheless, 79% of caregivers practiced familism and the earlier the generation, the stronger the influence of familism. A 2nd-generation daughter responded, "It was a natural discipline ... we knew we had to obey and not bring shame."

Theme 3: Acculturation—Two sub-themes, (a) Asian and Western ways of caregiving and (b) generational differences between caregivers and care recipients about caregiving, were explored.

Asian and Western ways of caregiving: Only a few caregivers expressed conflicts between their understanding of caregiving and that of their parents. The majority of caregivers, as assimilation theory suggests, showed a linear pattern in their understanding of Asian and Western ways of caregiving: the later the generation, the less conflict because parents' and caregivers' understanding of caregiving become similar as both assimilate to Western ways. Conflicts with their parents' expectations happened primarily between 2nd-generation caregivers and their parents (1st generation). As 2nd-generation daughters expressed,

when you have a parent who can't speak English, no matter how efficiently systems run, communication is a big issue ... plus a lot of times Asian culture is a hindrance especially Japanese culture, they want to be polite to authority figures, they all say "fine" even if they are not fine,

and

when you are dealing with my Mom, you have to proactively put out to the doctor, what you think it is or what they need to check ... the society that my Mom grew up and the society [now] is not the same ... if you have to complain, you have to complain, and if you have to say something, you have to say something. It doesn't matter they are authority figure or not ... You have to advocate if you want the kind of quality of care, you have to say something.

Contrary to such conflicts, 2.5- and 3rd-generation caregivers did not experience any differences because the parents spoke English and most likely their parents were also acculturated to Western ways.

Generational differences in caregiving: Similar to the pattern of Asian and Western ways of caregiving, there were conflicts among 2nd generation but none among 2.5 and 3rd generations. Although 2nd-generation caregivers differed in how they thought about caregiving and their parents' expectation, they understood their parents' stand; this is because their parents never experienced caregiving because of leaving Japan at younger ages and never returning to care for their parents in Japan. Therefore, 1st-generation parents do not understand the physical and mental hardship of taking care of elders. A 2nd-generation son expressed, "You are supposed to care for loved ones at home and you are not supposed to place them in a nursing home ... that was their belief. That's where it was in Japan that time." A 2nd-generation daughter said, "They [her parents] want their son or daughter to do everything because they had no experience in taking care of any old folks." In contrast to

1st-generation parents, parents of some 2.5- and 3rd-generation caregivers (i.e., 2nd-generation parents) did not want to be a burden to their children because the parents themselves cared for their own 1st-generation parents and parents-in-laws. Therefore, they had a better understanding of their adult children caregivers' situations.

Theme 4: Caregivers' own future care—Two sub-themes emerged: (a) in-home (professional) caregivers and (b) institutionalization.

Perception about in-home caregivers: Although only a few caregivers used professional in-home caregivers, all accepted the idea of receiving in-home caregivers for themselves if needed. One 2.5-generation daughter preferred an Asian caregiver because the caregiver had been exposed to the kind of "compassionate care that is typical of the [Asian facility]." A 2nd-generation daughter also preferred Asians but expressed, "Most Asians of our generation work in better jobs. There's not too many nurse's aides that are of Japanese descent." For the rest of caregivers, the race/ethnicity of in-home caregivers did not matter as long as they were dependable and qualified.

Perception about institutionalization: In contrast to 1st-generation immigrants, all three generations of caregivers accepted the idea of a long-term care facility for their own future care because they did not want their family members to do caregiving and impose their care on their children and relatives. A few of them had already toured potential facilities and others had invested in long-term care insurance. Sixteen caregivers preferred mainstream care homes (2nd: 5; 2.5: 4; 3rd: 7). Two 2.5-generation daughters did not have a preference because they are bilingual. One 2nd-generation caregiver chose an Asian facility because of food preferences. Preferences for mainstream facilities were due to acculturation level: "It doesn't matter because I have Asian culture inside me, but I was never around Asian people growing up" (3rd-generation daughter). Instead, they focused on the quality of the facility—compassionate care and respect.

Male caregivers expressed different sentiments from females regarding future institutionalization:

If I know I'm terminal or if I'm incapacitated, my plan has got to have something happen—a bad accident or something ... Just get in the car, step on the gas, open the window, right into the water and boom. That would be the place. (2.5-generation son)

We joked around it all the time ... We always say it sucks getting old. And if I get to that point, take me outside and shoot me. (3rd-generation son)

Male caregivers compared with female seemed to have a harder time accepting care and a stronger desire to keep their control and independence.

Discussion

The themes that emerged as noteworthy of discussion are (a) level of acculturation and filial responsibility, (b) dimensions of caregiving, (c) cultural values, (d) acculturation, and (e) caregiver's own future.

Level of Acculturation and Filial Responsibility

The quantitative results from the SL-ASIA scale showed later generation caregivers with a higher acculturation level. Findings regarding filial responsibility from the Filial Values Index supported the hypothesis of 2nd-generation caregivers having the highest level of a sense of filial responsibility. But this was not the case for 2.5- and 3rd+ generation caregivers, because 2.5-generation caregivers showed the lowest filial responsibility scores. This difference may be related to the ages of caregivers, because 2nd generation (75 years) were older than 2.5-generation (64 years) caregivers; the older caregivers tended to have stronger ties to their traditional caregiving culture and a stronger sense of filial responsibility. Moreover, when 2nd-generation caregivers cared for their aging parents, there were no long-term care facilities. Thus, they did not think to rely on outside help but to care for them at home. Besides, due to the parents' language barriers and food preferences, even if there had been care facilities, they would have been unable to meet their cultural needs. As clearly reported by 2nd-generation caregivers, caring for older parents was the norm among Japanese American sons and daughters.

Dimension of Caregiving

Some caregiving experiences of later generations, such as helping with English translation, were similar to what scholars (Kong, 2007; Mokuau & Tomioka, 2010; Sun et al., 2012) previously found among 1st-generation caregivers. Second-generation caregivers with 1st-generation immigrant parents and 2.5-generation caregivers with Kibei parents experienced more caregiving difficulties, due to their parents' limited English proficiency and inability to drive. Accordingly, 2nd- and some of 2.5-generation caregivers' duties started once they were able to answer the phone and obtained drivers' licenses. However, 3rd-generation caregivers did not have to worry about English and driving issues because as assimilation theory posits, their parents were U.S.-born, their primary language was English, and they were able to obtain their drivers' licenses.

This generational difference was even clearer in caregiving attitudes, especially their decision to utilize outside help. Both 2.5- (one case) and 3rd-generation (five cases) caregivers used in-home caregivers; however, these in-home caregivers were not "Japanese-speaking" but met the "qualifications" as caregivers. The reasons using in-home caregivers were primarily to benefit the caregivers' physical and mental well-being: "I needed to have a life, too" and "needed to do something else" (3rd generation). Furthermore, across all generations, many caregivers placed their loved ones in an assisted living or skilled nursing facility once they became available (2nd and 3rd: 50%; 2.5: 75%). This occurred because the level of ADL help required was more than caregivers and their families could handle and because of concern for the care recipient's safety. Their greater utilization of residential facilities may be because there is a Japanese American assisted living facility with Japanese-English bilingual care workers, Japanese food and cultural activities, and skilled nursing facilities with Asian professional caregivers in Seattle. Moreover, this skilled nursing facility has been a default option when Asian patients are to be discharged from hospitals.

Cultural Values

Differences in caregiving attitudes between caregivers and their families across generations indicated variations in the level of cultural maintenance and resistance to the idea of institutionalization, due in part to the immigration history of Japanese Americans. Both the Japanese American–owned assisted living facility and nursing home offer multiple languages, encompassing not only later generations of Japanese care recipients but also those from other racial/ethnic groups. Later generation Japanese care recipients are receptive to this “modified” environment where there is still some familiarity with Japanese culture. Placing their loved one in a long-term care facility did not mean that the level of filial responsibility (e.g., frequency of care involvement) became less for caregivers across generations, however. After placing their loved ones in institutions, 2.5- and 3rd-generation caregivers showed continued filial responsibility by visiting daily and providing companionship: “Because mother is in a nursing home, it’s not required that [we have to go]” but we go to “make sure to have somebody with her [mother] at each meal time [by taking turns among siblings].”

Acculturation

Congruent with the findings of previous studies among 1st-generation immigrant care recipients and caregivers (Funk et al., 2013; Hsueh et al., 2008; Kong et al., 2010; Zhan, 2004), disagreements about caregiving expectation between care recipients and caregivers were due to differences not only by generation but also by extent of acculturation to Western culture. However, such disagreements were limited to 2nd- and 2.5-generation caregivers and their 1st-generation parents, a pattern supporting linear assimilation. Japanese American generations are so distinct in their characteristics and life experiences that each generation has its own name: *Issei* (1st generation), *Nisei*, *Kibei* (*Nisei*), and *Sansei*; in addition, their assimilation processes are clearcut (Itai & McRae, 1994). Similar to previous studies among 1st-generation care relationships, *Issei* immigrants had caregiving beliefs and expectations based on the caregiving practices in Japan at that time. Their *Nisei* children struggled but managed to practice Western ways of caregiving, including institutionalization, and *Issei* parents accepted the discrepancies between their own and their Westernized children’s expectations. Assimilated to mainstream culture, 2.5- and 3rd-generation caregivers included institutionalization in their care systems.

Caregiver’s Own Future Care

Within the Japanese traditional culture of not disagreeing with authority figures, especially women were socialized not to speak their opinions. Moreover, those 1st-generation immigrants did not have a chance to care for their parents who remained in Japan and thus had no caregiving experience. Therefore, when their 2nd- and 2.5-generation children offered assistance and proposed the idea of an institution, 1st-generation parents accepted help and agreed rather graciously to move into long-term care facilities. This pattern continued across Japanese American generations, and the majority of later generations within this sample chose to not rely on their children for care but to be in a mainstream long-term care facility.

Future Implications

Implications for Research

An in-depth analysis of the reasons and motivations for Japanese Americans' high level of caregiving involvement even after placement in a long-term care facility is necessary. Examining motivational differences between caregivers who use only in-home care and community-based services versus institutional care is another understudied topic. Samples with more diverse socioeconomic backgrounds should be included, especially among later generations. There was a 10-year gap between 2nd- ($M = 74.6$ years) and 2.5-/3rd-generation ($M = 64.4$ years) caregivers. The socioeconomic background of 2nd-generation caregivers was most likely lower than later generation caregivers. Educational and professional opportunities were not as available, particularly for women, as they were for later cohorts. Thus, their choice of institution may have been limited to skilled nursing facilities that accept Medicaid. Caregivers from later generations were highly educated and had the means to hire paid caregivers and/or pay privately for their assisted living and skilled nursing facilities. Thus, the results may reflect the relatively high socioeconomic status of this later generation sample. Future studies might include bi-/multi-racial caregivers to explore their caregiving experiences in relation to culture and acculturation. This study included four interracial couples (two 2.5 and two 3rd generation). Depending on the spouses' racial and ethnic groups, cultural values of filial responsibility, willingness to accept partner's culture, and immigrant generation may result in different caregiving experiences. Caregivers' gender within bi-racial couples or caregivers themselves being bi-racial (i.e., half-Asian) may influence different perspectives on filial caregiving. Another area for further investigation is the perception of institutionalization by later generations of caregivers and what they expect in terms of "quality," "compassionate care," and "respect."

Implications for Practice

This study was feasible because it was conducted in a city where multiple generations of Japanese American communities have been well established over decades, including comprehensive Japanese senior social service agencies. This condition is not representative, however. Thus, there is a need for outreach to communities where ethnic-specific services are not available while these ethnic-specific agencies need to consider services that reflect the needs of acculturated, later generation ethnic caregivers.

Regardless of generation, caregivers' willingness to openly share their caregiving experiences and views about their loved ones with the researcher was noteworthy. This suggests that ethnic-specific support groups might be helpful for later generations of Japanese American or Asian American caregivers where they could share their experiences with those who are new to caregiving and make recommendations to others within the same ethnicity and generation. In a support group setting within ethnic-specific community agencies, those who had placed their loved ones in institutions might be able to encourage others to do the same.

Limitations of the Study

This study was conducted within racially and ethnically diverse neighborhoods with historically service-rich environments. Using convenience sampling, some caregivers were originally referred from ethnic-specific agencies that are biased to their service users, and thus findings are generalizable only to similar settings. Those from ethnic-specific agencies may have stronger ties with their ethnic communities, and the results may reflect these ties. Despite their caregiving challenges, those who volunteered to share their experiences generally had satisfying ones and their stories tended to be positive, regardless of generation. Some participants provided care for their loved ones more than 10 years ago and this may result in recall biases. Participants were independent, active, well-educated, employed professionals or financially comfortable homeowners. In many ways, they differ from what has been known to be the “typical” caregivers in national studies, who experience stress and burden, disruptions to employment, and resultant health problems (National Alliance for Caregiving, 2009).

Conclusion

The present study explored the sense of filial responsibility and caregiving experiences of three later generations of 21 Japanese American caregivers of older adults in the Seattle metropolitan area, which is the first study to explicitly compare multiple caregiver generations within an Asian sub-ethnic group. The SL-ASIA scale and the Filial Values Index measured caregivers’ acculturation and filial responsibility levels. Within the framework of Gordon’s assimilation theory, later generations showed higher levels of acculturation; however, the filial responsibility scores exhibited a high level of sense of filial responsibility among 3rd-generation caregivers and thus were only partially congruent with assimilation theory. Qualitative data also revealed later generation caregivers’ strong sense of filial responsibility and continued caregiving involvement, even after the institutional placement of their loved ones. These findings not only expand existing knowledge but also point to the need to develop caregiver services that take account of their culture, generation, and level of assimilation.

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Biography

Christina E. Miyawaki, PhD, MSW, received her MSW from the University of California, Berkeley, and PhD in Social Welfare from the University of Washington. Her research focuses on health and health disparities of older adults of color and their caregivers including immigrants. Currently, she is an NIH T32 postdoctoral fellow at Group Health Research Institute, affiliate investigator at the University of Washington Health Promotion Research Center, and Healthy Brain Research Network (HBRN) Scholar at the CDC-HBRN Coordinating Center in Seattle, Washington.

Table 1

Themes and Sub-Themes.

Themes	Sub-themes
Dimension of caregiving	Type of assistance provided
	Caregiving challenges
	Coping strategies
	Informal support
	Formal support
Cultural values	Sense of filial responsibility
	Familism
Acculturation	Asian and Western ways of caregiving
	Generational difference in caregiving
Caregivers' own future care	In-home (professional) caregivers
	Institutionalization

Table 2

Characteristics of Caregivers (CG) by Generation.

Generation	Gender	Age	CG's marital status	Children below 18	Paid employment	Educational background
2nd-1	Female	58	Married	No	Yes	Graduate degree
2nd-2	Female	60	Married	No	Yes	College degree
2nd-3	Female	86	Married	Yes	Yes	Some college
2nd-4	Male	86	Married	Yes	Yes	Some college
2nd-5	Female	87	Married	Yes	Yes	Some college
2nd-6	Female	90	Married	Yes	No	Some college
2nd-7	Female	55	Single	No	Yes	College degree
<i>M (SD)</i>		74.6 (15.94)				
2.5-1	Female	58	Married	Yes	Yes	Graduate degree
2.5-2	Female	65	Single	No	Yes	Graduate degree
2.5-3	Male	68	Married	No	Yes	Graduate degree
2.5-4	Female	58	Married	Yes	No	College degree
2.5-5	Female	69	Married	Yes	No	Some College
2.5-6	Female	70	Single	Yes	Yes	Graduate degree
2.5-7	Female	63	Married	Yes	Yes	Graduate degree
<i>M (SD)</i>		64.4 (5.00)				
3rd-1	Female	61	Married	Yes	Retired	College degree
3rd-2	Female	72	Married	No	Yes	Graduate degree
3rd-3	Female	65	Married	No	Yes	Graduate degree
3rd-4	Male	54	Married	No	Yes	Some college
3rd-5	Female	72	Married	Yes	Yes	Some college
3rd-6	Female	61	Married	No	Yes	College degree
3rd-7	Female	66	Married	No	Yes	Graduate degree
<i>M (SD)</i>		64.4 (6.45)				
Overall	86% (F)	67.8 (10.96)	86% (M)	52% (Y)	81% (Y)	33% < college 24% College 43% Graduate

Note. F = female; M = married; Y = yes.

Table 3

Caregiving Conditions by Generation.

Generation	Care recipient	No. of siblings	Total caregiving duration (years)	Caregiving years prior to institutionalization	Co-residence prior to institutionalization	Professional caregiver prior to institutionalization	In institution
2nd-1 ^a	Mother	1	22+ ongoing	12	No	No	Yes (10 years)
2nd-2 ^a	Father	1	1	1	No	No	No ^b
	Mother		9	8			Yes (1 year)
2nd-3 ^a	Mother	4	13	13	Yes	No	No ^b
2nd-4 ^a	Father	3	11	11	No	No	No ^b
	Mother		41	32	No	No	Yes (9 years)
2nd-5	Mother	5	11	6	No	No	Yes (5 years)
2nd-6 ^a	Mother	2	15	5	No	No	Yes (10 years)
2nd-7 ^a	Mother	1	21+ ongoing	21	Yes	No	No
% of current caregivers, <i>M</i> (<i>SD</i>)				12.1 (9.39)	28.6% (Yes)	0% (Yes)	55.6% (Yes)
2.5-1 ^a	Mother	9	30+ ongoing	25	Yes	Yes	Yes (5 years)
2.5-2	Mother	2	18+ ongoing	18	Yes	No	No
2.5-3	Mother	2	10+ ongoing	7	No	No	Yes (3 years)
2.5-4 ^a	Mother	1	5+ ongoing	3	Yes	No	Yes (2+ years)
2.5-5 ^a	Father	3	10+	10	No	No	No ^b
	Mother		13+ ongoing	9			Yes (4+ years)
2.5-6	Father	0	7	6	Yes	No	Yes (1 year)
2.5-7	Mother	2	10+ ongoing	2	No	No	Yes (8 years)
% of current caregivers, <i>M</i> (<i>SD</i>)				10.0 (7.82)	57.1% (Yes)	28.6% (Yes)	75.0% (Yes)
3rd-1	Mother	3	25+ ongoing	10	Yes	No	Yes (15 years)
3rd-2	Mother	0	10+ ongoing	3	No	Yes	Yes (7 years)
3rd-3	Father	2	2	2	No	Yes	No ^b
	Mother		5+ ongoing	1			Yes (5 years)
3rd-4	Father	3	3	3	Yes	No	No ^b
	Mother		17+ ongoing	17		Yes	No

Generation	Care recipient	No. of siblings	Total caregiving duration (years)	Caregiving years prior to institutionalization	Co-residence prior to institutionalization	Professional caregiver prior to institutionalization	In institution
3rd-5	Father	0	4	4	Yes	No	No ^b
	Mother		12+ ongoing	4		Yes	Yes (8+ years)
3rd-6	Mother	3	1	1	No	Yes	No ^b
3rd-7	Mother	2	13	12	No	No	Yes (1 year)
% of current caregivers, <i>M(SD)</i>			50.0%, 9.2 (7.71)	5.7 (5.42)	42.9% (Yes)	44.4% (Yes)	50.0% (Yes)
Mother	74%	Overall <i>M(SD)</i>	12.5 (8.66)	9.2 (7.33)	38.1% (Yes)	20.8% (Yes)	59.3% (Yes)
Father	26%						

^aParents with poor English proficiency and caregiving started once caregivers obtained driver's license.

^bNever required institutional placement.

Table 4

Results of the Suinn-Lew Asian Self Identity Acculturation Scale and the Filial Values Index Scores by Generation.

		Filial values (1-9)			
		Acculturation (1-5)		<i>M (SD)</i>	
Generation	Age <i>M (SD)</i>	<i>M (SD)</i>	Responsibility	Care	Respect
2nd	75 (15.94)	3.0 (0.25)	8.1 (1.11)	8.4 (0.48)	8.3 (0.70)
2.5	64 (5.00)	3.4 (0.37)	6.4 (1.35)	7.6 (0.57)	8.3 (0.68)
3rd	64 (6.45)	3.6 (0.26)	7.0 (1.56)	8.0 (0.97)	8.5 (0.38)

Note. Scores: 1 = *low*, 3 = *bicultural*, 5 = *highly acculturation*. Score range: 1 = *completely disagree*, 9 = *completely agree*.