

Home Care Work Organization and Health: Do Hispanic Women Have Different Concerns?

S. Sonia Arteaga

University of Maryland Baltimore County

Jeanne Geiger-Brown

Carles Muntaner

Alison Trinkoff

Jane Lipscomb

University of Maryland, Baltimore

Linda Delp

University of California, Los Angeles

Home care is one of the most rapidly expanding segments of the health care industry, with both demographic and fiscal pressures ensuring that this type of care will continue into the future. Much of the care is provided by low-wage workers, mostly women, without the typical protections and benefits that workers in traditional health care settings receive. The purpose of this qualitative study was to describe the experience of a sample of home care workers. Four focus groups were held, three with ethnically mixed groups, and one with exclusively Hispanic workers. Four major themes emerged: physical demands, emotional drain, compensation issues, and benefits of the work. Although some Hispanic women might be at greater risk of overexploitation because of language barriers and immigration status, there were no major differences noted between the health concerns of Hispanic and non-Hispanic home care workers. The themes identified seemed to cut across cultures and ethnicity for workers in home care.

El cuidado en el hogar es uno de las áreas que más rápidamente se está expandiendo de la industria del cuidado de la salud, con presiones demográficas y fiscales asegurando su permanencia. Gran parte del cuidado lo proveen trabajadores de bajos ingresos, en su mayoría mujeres, sin las protecciones y los beneficios que normalmente reciben trabajadores en sectores tradicionales del cuidado de la salud. El propósito de este estudio cualitativo fue describir la experiencia de una muestra de trabajadores de cuidado en el hogar. Se estudiaron cuatro grupos focales: tres compuestos de trabajadores de diferentes etnias y uno de trabajadores exclusivamente hispanos. Emergieron cuatro temas principales: demandas físicas, agotamiento emocional, asuntos de compensación y beneficios del trabajo. Aunque algunas hispanas posiblemente corren mayor riesgo de ser explotadas debido a las barreras de lenguaje y su estado de inmigración, no hubo diferencias notables entre las preocupaciones de salud de los trabajadores hispanos y los no-hispanos. Los temas identificados eran los mismos para los traba-

It is estimated that the health care industry is the second-fastest growing sector of the US, with more than 12 million workers employed in the industry (Bureau of Labor Statistics, 1999). The aging population and burgeoning health care expenses have contributed to an increased need for home health care services (Szasz, 1990; Burbridge, 1993). Home health care is seen as a positive and cost-containing alternative to nursing home placement or hospitalization (Kenney, 1993). The provision of

home health care services allows physically frail clients to remain at home while receiving the health care and supportive services that they need. Supportive services provided by home care workers are one component of this care. These services include housekeeping, personal care, psychosocial support, and transportation.

Home care workers are drawn from low-paid labor pools, which contain increasing numbers of ethnic minority women, including immigrants (Neysmith &

Aronson, 1997). They face many occupational hazards, such as workplace injury and musculoskeletal disorders. The majority of physical injuries are related to overexertion injuries and falls, followed by motor vehicle accidents (Bureau of Labor Statistics, 1997; Meyer & Muntaner, 1999). Furthermore, home care jobs tend to be high-stress jobs that are combined with low control over the work environment (Soderfeldt et al., 1996). For example, workers sometimes have to cope with physically or verbally abusive clients (Najera & Heavey, 1997). Past research has found that home health care workers are likely to lose more days from work than their nursing home counterparts (Meyer & Muntaner, 1999). But despite the apparent negative aspects of the job, past research has suggested that many home care workers have positive attitudes toward their jobs and their clients (Weiler, 1998).

The paucity of research on the impact of occupational hazards on home health care workers warrants increased attention. This qualitative study reports on themes generated from focus groups with home health care workers who explored the health issues associated with their work. Special attention was given to the health status concerns of Hispanic home health care workers. Since Hispanic women are often portrayed in the literature as more traditional and family oriented than White or African American women (Hirsch, Higgins, Bentley, & Nathanson, 2002; Navarro, 2002; Robinson & Swanson, 2002), it was important to ascertain whether Hispanic women would have a differing appraisal of the health consequences of home care work.

METHOD

Participants

Home health care workers were recruited through local Service Workers' International Union (SEIU) chapters in southern California. Workers attending the union's home care worker training center were approached and invited to participate in the focus groups. None of those approached refused to participate. No compensation was given for participation in the focus groups.

A total of 44 women participated in the study, one third of them Latina and the other two thirds white or African American. The population of home care workers in this region is predominantly minority, with 39% Latino, 25% African American, 10% Armenian, 4% Russian descent, and 7% Asian. Half are foreign born, and 31% are naturalized citizens (Cousineau, 2000). Half have family incomes below the federal poverty level. Two thirds care for a relative. We did not collect demographic data other than preferred language for these participants, and thus cannot compare focus group participants to the overall home care worker population.

Procedure

A total of four focus groups were held with 10 to 12 women in each group. Three of the groups were conducted in English, and one was conducted in Spanish; all but the Spanish-language group were racially mixed. A trained interviewer led the discussions in English and Spanish. Focus groups lasted about an hour and were tape-recorded. After scripted introductions, the facilitator asked general questions about how the women's work affected their health, including their functioning in their family and community (Figure 1). Few prompts were required, since the participants readily volunteered both negative and positive comments about their work and its influence on their health.

Data Analysis

All of the focus groups were tape-recorded and transcribed verbatim. A bilingual graduate student transcribed the Spanish audiotape into English. The translation was checked for accuracy by a second Spanish-speaking author. Thematic analysis of the content was performed by coding meaningful segments of the transcript and then grouping these inductively into categories (Kreuger, 1988). Two authors coded all studies and achieved final agreement on the coding formulation presented here.

FINDINGS

Four major themes emerged from the transcripts: physical demands, emotional drain, compensation issues, and the positive value of work. While all of the themes mentioned were identified from both English-speaking and Spanish-speaking focus groups, there were additional unique concerns raised by the Spanish-speaking focus group members that will be reported separately. In all of the themes discussed below, workers' comments are from both Hispanic and non-Hispanic workers, with the exception of the final section, where unique concerns of Hispanic workers are discussed.

Physical Demands

Home care workers experienced several sources of physical demands that affected their health. These demands included lifting patients and carrying heavy supplies, and exposure to secondhand smoke. Clients with physical disabilities required the same heavy lifting that teams of workers perform in hospitals, yet home care workers accomplished these functions alone and without lifting devices.

She weighed 400 and some pounds. I had to turn her over, bathe her, do it all by myself. The family didn't want no parts of her.

She's got a little bell she rings and this lady falls constantly . . . and she was like "can you pick me up." Well I have to have a back brace, or whatever.

English Focus Groups

Introduction

... We are now going to ask you a few questions for a project that the University of Maryland is doing in collaboration with SEIU to learn about the health and work-life concerns of home care providers. Some studies in other countries strongly indicate that the working conditions among today's folks can be damaging to physical health and emotional well-being. However, we lack this kind of information in the US.

1. How do you think your work affects your health? By health we mean all the things that affect how you feel physically and emotionally and how you function in your community, family, and life.

2. What about your job helps you stay healthy?

3. What about your job affects you in a negative way?

Closing statement: Thank you very much for your participation. Your comments will help the researchers design surveys that will give information to help improve the lives of home care providers.

Spanish Focus Group

Presentacion

... Ahora vamos a hacerles unas cuantas preguntas para un proyecto que la Universidad de Maryland esta haciendo en colaboracion con SEIU para aprender sobre la salud y los problemas en el trabajo de los proveedores de servicios domiciliarios. Algunos estudios en otros paises indican claramente que las condiciones de trabajo de los proveedores de servicios domiciliarios contemporaneos pueden ser nocivas para la salud fisica y emocional.

1. Como crees que el trabajo te afecta la salud? Por salud entendemos todas las cosas que te afectan como te sientes fisica y emocionalmente, y como te van las cosas en casa, en tu comunidad, y en la vida en general.

2. Que tal como el trabajo te ayuda a mantener la salud?

3. Que tal como el trabajo te afecta de forma negativa?

Despedida: Muchas gracias por su participacion. Sus comentarios van a ayudar a los investigadores en el diseno de encuestas que proporcionaran informacion para mejorar la vida de los proveedores de servicios domiciliarios.

Figure 1. Interview schedule for focus groups (see Kreuger, 1988).

I lifted an electric wheelchair and with my other hand I vacuumed and I... felt a "click" and then the following day I had pain... on the third day they took me in a wheelchair.

... she went down stairs and thump, she fell. I told myself I would not lift her up... because she is a large woman and I might hurt my back and even though it is

already hurt... I called my 19-year-old son... he had difficulty lifting her because her bones are very heavy... He did it with such effort that if I had done it... [laughs]

Because workers were in the client's home, they were not protected by workplace regulations that promote worker health and safety. Exposure to cigarette smoke was one unpleasant demand.

OK. I am a nonsmoker. My client is the kind of person that smokes a lot. I get some very sore throats. It makes me kind of sick. You know all that smoke coming into my lungs... They are heavy smokers in that you can smell it in the whole house. You can't tell them would you not smoke, or anything like that.

When sick, many home care workers did not have paid sick time as most other health care workers do, and they had no replacement worker to care for their client; thus many worked while sick. Those workers who were uninsured often avoided taking care of themselves because being seen by a medical provider required waiting all day in a clinic. This would take time away from caring for their client, causing them to lose needed income.

There is no one that I can call and say you know I'm sick today... I don't want to go to work. Can you take my place... So I have to go if I'm sick with a cold, if I have the flu I have to get up out of my bed anyway and go to work because mother, or father they're not going to be able to get up.

... if you work those long hours, those 12-hour shifts like I worked, you know, and you have other things that you are doing in your life, you don't have 8 hours to sit up in a free clinic, you know, waiting for to be treated for a cold.

You have to find your own [substitute] and the money has to come out your pocket to pay them and somebody that you trust.

Emotional Drain

In addition to the physical demands of the job, many of the women reported that clients' negative attitudes toward them affected their emotions. Clients were sometimes very manipulative.

Yes, it's true, it also affects one's emotional side because sometimes the elderly have psychological problems, aside from physical ones. On certain days they will treat you well and on other days they will treat you poorly.

My grandmother is ninety years old and is someone very, how do you say, very strong in character. She thinks she can manipulate and can control everyone as she pleases... and you tell her and give her advice and she still does not listen.

Workers witnessed the distress of disabled and ill patients on a daily basis without breaks, and without the support of other workers. At times the worker's distress came from witnessing abuse or neglect of the clients by their family.

When their family dumps them on you and leaves you to take care of them like babysitters. And they will be wondering where their family is and how come their family don't come . . . sometimes you may have to deal with a family member . . . [who] is contrary.

The emotional burden on the worker increased when the client was a family member. This was true for both Hispanic and non-Hispanic home care workers.

Well yes, it affects my health to see her [family member] sick. Well yes, it makes me very sad and sometimes at night and I can't sleep, thinking why God has done this, why did he do this to me.

Yes, um, that affects one emotionally, a great deal, especially if one is taking care of a family member. In my case, I have taken care of my mother for nine years. It affected me a great deal emotionally, it was very stressful, but at the same time, it made me love her more, enjoy her more, enjoy every day as if it was the last day.

Home health care workers described working for clients who were suspicious or accusatory and believed the health care worker had lied. Logical persuasion did not remedy the situation, and the workers often took extraordinary measures to try to convince the patient of their innocence.

[She] had a patient that was scared of people robbing her . . . she would arrive and the patient would put money, about a thousand dollars, wrapped in paper in the refrigerator. The day she had to clean the refrigerator, the patient said, "You stole it from me, you stole it." The woman said, "No, I didn't, it's right there." The patient did not know the money was there. The woman would clean, then the patient would say, "You stole it and it's not there, I want to see it." The patient would always say, "I've been robbed, I've been robbed."

. . . one day she got it in her head that her clothes were at the cleaner. I told her, "No, your clothes are not at the cleaner, I brought them home. Look here they are hung up." She would say, "No that's not it, that's not it." . . . So I took her to the cleaners. She told the cleaner that if he didn't give her her suit, she was going to call the police. . . . Finally, I said, "Your clothes are at your house, let's go, there they are." She was very mad because they could not find her clothes at the cleaners. . . . She called the police. . . . The women and myself were in the police car because I was going to show them that her clothes were in her house.

Workers complained of interrupted sleep, often when caring for a relative in their own home without relief. They lost sleep for two reasons: first, from telephone calls or pages received from clients while sleeping, and second, when their client lived in the worker's home and they felt responsible for the client's safety and comfort during the night. Many workers also had their own families to care for after the demands of their workday, and the loss of restorative sleep was seen as a cause of physical health problems as well as emotional distress.

. . . a lot of times I stay up like a lot of nights because she is uncomfortable and then she is constantly . . . I don't know if she is in pain, or she complains but she just hollers

and fusses all night because she is uncomfortable. So, sometimes it is stressful because you don't really know what to do. . . . I want her to be comfortable.

. . . they may have certain hours that they are supposed to be working but if you're there, come on. If that person is calling you from their room and they're ill . . . how can you sleep . . . and I'm the type person even in my own home if someone is sick and I know they have a toothache or whatever, I can't sleep because they can't sleep.

. . . if I were to tell you the countless number of nights where I did not sleep. I trembled for weeks because my nerves were shot, but I kept on going because it was my job.

The clients of home care services were often elderly and suffered from dementing brain conditions; as such, they sometimes threatened violence to the caregiver during the provision of needed care. Since the worker was often alone in the patient's home, there was no "back-up" team to assist when they were threatened; the threatened exposure to violence was emotionally stressful for the workers.

Yes, I suffered with the man I took care of because he . . . had a half a body; he was handicapped. He would say he was going to hit me; he was going to break my head. . . . some throw things at you . . .

He liked to hit the mother-in-law, and the mother. He would hit them hard. . . . And he would also hit the wife. I saw him as if he also wanted to hit me. I told him, "You are not going to hit me because I will hit you back. If they do not hit you, I will hit you." And he said, "Do you really think that I am scared of you, caca?"

Workers reported becoming disabled when the demands of work became too much for them to endure. The multiple responsibilities of taking care of more than one client as well as taking care of their own personal family took a toll on the health status of these women, including their emotional health.

The doctor had to put me on disability for 6 months [she was caring for three clients, four children and a husband].

It is very stressful. I went to work and I worked for two years and just last May I got so stressed out that I went to the doctor. . . . I needed to be on disability so I wanted to take off a year. So I stopped home care and I stopped everything and I went on disability and I'm just now getting back to work.

Compensation Issues

Workers expressed a sense of responsibility for their clients that extended beyond normal work hours, often reinforced by client contacts in off-work hours. They did not receive additional wages for this time. Workers experienced a sense of being devalued when clients refused to pay their share of the worker's wage, when social workers assigned too few hours to deliver needed care, or when the compensation system did not recognize the unique aspects of their work. They also reported feeling hurt when clients fired them after they had invested effort in caring for the client.

A frequently mentioned theme was that the demands of caregiving bled into the worker's personal time. Some workers found this to be a burden, and others encouraged their clients to remain in contact during off-work hours. When the caregiving occurred in the worker's home, separating work and private time was naturally more difficult to manage.

The first day I started working with her, she called me xx times on the telephone. I would try to heat a tortilla to eat and it would burn. The following day I told her, "Please, I will work with you, but do not call me on the phone. I do not have time to attend to the phone, I have things to do." She would call me and say, "hello are you there?" "Yes," I say, "I am sleeping." . . . It affects me.

I [do carry a pager] because I place myself in that predicament where I said I'm going to take care. When I say I'm going to take care that means I'm 24/7. I'm there with you to do everything that you're going through. . . . if you need to just talk, if you need to scream; you need to holler, call me. If you need something, or something happens to [you] then call me.

In addition to the burden of caring for the patient, bureaucratic issues such as having to collect fees, deal with workman's compensation problems, and advocate for needed hours to provide appropriate care were cited as emotionally draining.

This lady had 8 hours on her day . . . so she came to live in my house and I took care of her. . . . She liked the food to be perfect. She liked it cooked a certain way. And if it wasn't she would say, "I'm not eating this garbage. Take it away." And then she would call . . . the police and say that my husband and I talked bad to her and talked down. . . . I had to go to court to get her out of my house. . . . And she wanted the 8 hour money to pay her rent . . . the money that I was getting for taking care of her she wanted that to be rent money too.

I tried for workman's comp. . . . But if you got three consumers. Like I hurt my feet with one consumer when it was time for the bus drive, when the bus went on strike. I hurt my feet. They told me that if I stopped I'd get workman's comp for only one consumer. . . . What about the other two I work with.

Just because it's a family member they do cut your hours. My cousin took care of her husband they gave her 2 hours. He had Alzheimer and she would have to feed him, bathe him, and she would have to sit there, you know, when she'd feed him. Tell him to chew and all that took time and her 2 hours was gone just bathing him and watching him chew.

. . . because she lived in Beverly Hills . . . they gave her 8 hours just because she is out there and just because who she was.

Some women remarked about how difficult it felt after being fired from a job, especially after they had invested significant effort in the relationship to ensure that the client's needs were being met. Since these workers were low-wage earners, job insecurity had a significant impact on their financial and emotional health.

When you go to a patient's house and you go up there you go break your neck. Cleaning the walls, shining up everything and then the family decides they don't want you to take the job. So boom you're out of work . . . when you've done all the work to get them situated . . . after all the work is done you are . . . no longer needed.

She had no teeth; she had to eat mashed potatoes. I ran [around] to the doctors because she had a very bad heart. I got her teeth in her mouth. Got her glasses and she told me not to come back. And that hurts. It does hurt. It hurts yes.

Rewards of Work

Despite the hardships of the job, the overwhelming majority of the women reported enjoying the work despite the many challenges they faced. Some of the women stated that their work made them stronger while keeping them on their toes. "And basically it made me stronger, it made a stronger person. And it [the job] helps one have compassion for others and mentally it is a learning experience. It's a challenge and how to meet these challenges is a great thing . . . it keeps you alert. You have to be on your toes."

Furthermore, many of the women expressed compassion and altruism for their clients. A few of the women mentioned that they viewed their work as a "calling" because they enjoyed helping others in need.

Then one starts to, um, love them so much, that [the client] also become a part of [our] families and you know that people are depending on you.

He would insult me . . . I would not get tired all day. And that's how I was. I was so sad when he died. I had loved him like family.

I am happy, I do it as a service for God. I don't do it with the intention of getting paid . . .

I worked as a nurse [in my country] for a while and then I concentrated on working with the elderly because the medicine that is practiced here [in the US] is not in concert with my customs. So I prefer to earn less and work for an hour with an elderly person that really needs help.

At first he treated me poorly, very demanding with everything . . . he always had to be there, knowing what I was doing. It's a very strong tension, an extremely difficult tension. And I felt as if that pressure bothered me. But I continued to have patience with the understanding that eventually I felt sorry for him. I felt sorry for him and that no one else would be able to put up with him the way I did. So in time, I came to appreciate this person and I still work with him.

. . . it is a blessing, whenever you are able to do for another person.

Hispanic Workers' Challenges

Hispanic workers reported being taken advantage of by clients who exploited their limited English ability, causing them to receive less compensation than was due them.

. . . he never, never in five years paid me "share of costs." I came to a training here at the union . . . they gave us a general class about what was deducted from our checks. So then I told them, when they explained it to me,

that he had never [in five years] given me the money, my boss. . . . He should have given me \$xx per month. But he never told me of that, even though I read a little of English, I speak a little bit of English. . . . So he deducted that from me for x years. When I realized it I called the union and told them that he had never paid me that. . . . They called him from here . . . and he said that he had paid me. It was a lie.

DISCUSSION

Themes raised by the focus group participants suggest that home care work has the potential to be hazardous to both the physical and mental health of workers. Furthermore, the demands of the job are often not controllable by the worker. For instance, the level of physical burden reported by the workers is likely to result in physical injury to them. Yet they have little choice but to perform the necessary tasks such as lifting, even though injury may mean a loss of livelihood given the marginal nature of the incomes of these women. Prior research has also suggested that interpersonal interactions and affectively charged situations with clients can be a source of stress for home health care workers (Bartoldus, Gillery, & Sturges, 1989). Additionally, a low-wage income and minimal benefits may also contribute to low job satisfaction among home health care workers (Bartoldus et al., 1989; Gilbert, 1991). In spite of the many hardships associated with home health care, many workers also perceive personal benefits from performing this service. The development of close personal relationships with home care clients can be a rewarding aspect of the job (Chichin, 1992).

The need for more research on Hispanic caregivers has been noted in the current literature (Morano & Bravo, 2002). Previous research suggested that difficulties such as language barriers and immigration and minority status (Aranda & Knight, 1997) may place workers at risk. Others suggest that Hispanic culture, such as reliance on family members in time of crisis, protects them against the hazards of ill health (Connell & Gibson, 1997; Guidry, Aday, Zhang, & Winn, 1997; Inclan & Hernandez, 1992; Samaan, 2000). Hispanic women have been reported to have a strong sense of family obligation (Navarro, 2002; Robinson & Swanson, 2002). A study found that Hispanic Alzheimer's patients were more likely to be taken care of by a woman relative than by non-Hispanics (Mintzer et al., 1992).

Despite some limited indication of cultural variability in the response to home care work, our findings underscore the commonality of workplace hazards for home care workers (physical demands, emotional demands such as verbal abuse, financial stress, inadequate health care, fear of being fired) among both Hispanic and non-Hispanic caregivers. The literature on Hispanic health behaviors and mental health has often shown that cultural differences are

greatly reduced after socioeconomic position or gender has been considered (Golding & Lipton, 1990; Marks et al., 1987; Piotrowski, 1998). Other comparative studies of caregiving have failed to find specific cultural differences in perceived burden of care between Hispanic and Non-Hispanic caregivers (Stueve, Vine, & Struening, 1997).

The hazards identified by home care workers may also be relevant for other low-wage health care occupations such as nurse assistants (Meyer and Muntaner, 1999) and other human service occupations (Soderfeldt et al., 1996). In light of our qualitative data, it appears that efforts to raise wages and improve benefits, provide access to health care, and limit the amount of physical burden on the job would reduce the health-related hazards associated with home care work. For instance, lifting weight limitations and a reduction in exposure to secondhand smoking would not only decrease job stress but would also limit deleterious health consequences among the home health care workers. These interventions would also protect the emotional well-being of home care workers (Gilbert, 1991). Reduction of job insecurity is also important, but this might be difficult to achieve under the independent provider model (i.e., the California In Home Health Services model), since home care workers can be fired without notice and without redress.

RECOMMENDATIONS

Workplace regulations that require lifting equipment and transfer boards to be available, and insurance coverage to pay for these devices, may decrease the physical demands that many of the women reported. Furthermore, adequate compensation and benefits could alleviate some of the financial burdens and workplace difficulties (e.g., lack of backup providers) that affect the workers' health. Many of the workers indicated that the development of close relationships with their clients was closely related to satisfaction with their job. Hence, home health care agencies should focus on how they can facilitate a home care environment that will allow for the development of these types of rewarding relationships while promoting the health of home care workers, since they are playing an increasing large role in the delivery of health care.

REFERENCES

- Aranda, M. P., & Knight, B. G. (1997). The influence of ethnicity and culture on the caregiver stress and coping process: A sociocultural review and analysis. *Gerontologist, 37*(3), 342-354.
- Bartoldus, B., Gillery, B., & Sturges, P. J. (1989). Job-related stress and coping among health-care workers with elderly people. *Health & Social Work, 14*(3), 204-210.
- Burbridge, L. (1993). The labor market for home care workers: Demand, supply and institutional barriers. *Gerontologist, 33*(1), 41-43.

- Bureau of Labor Statistics. (1997). *Injuries to caregivers working in patients' homes*. Washington, DC: United States Department of Labor.
- Bureau of Labor Statistics. (1999). *Occupational outlook handbook*. Washington, DC: US Department of Labor.
- Chichin, E. R. (1992). Home care is where the heart is: The role of interpersonal relationships in paraprofessional home care. *Home Health Care Services Quarterly*, 13(1-2), 161-177.
- Connell, C. M., & Gibson, G. D. (1997). Racial, ethnic, and cultural differences in dementia caregiving: Review and analysis. *Gerontologist*, 37(3), 355-364.
- Cousineau, M. (2000). *Providing health insurance to IHSS Providers (Home Care Workers) in Los Angeles County*. Report to the California HealthCare Foundation.
- Gilbert, N. (1991). Home care worker resignations: A study of the major contributing factors. *Home Health Care Services Quarterly*, 12(1), 69-83.
- Golding, J. M., & Lipton, R. I. (1990). Depressed mood and major depressive disorder in two ethnic groups. *Psychiatric Research*, 24(1), 65-82.
- Guidry, J. J., Aday, L. A., Zhang, D., & Winn, R. J. (1997). The role of informal and formal social support networks for patients with cancer. *Cancer Practice*, 5(4), 241-246.
- Hirsch, J. S., Higgins, J., Bentley, M. E., & Nathanson, C. A. (2002). The social construction of sexuality. *American Journal of Public Health*, 92(8), 127-128.
- Inclan, J., & Hernandez, M. (1992). Cross-cultural perspectives and codependence: The case of poor Hispanics. *American Journal of Orthopsychiatry*, 62(2), 245-255.
- Kennedy, G. (1993). How access to long-term care affects home health transfers. *Journal of Health Politics, Policy and Law*, 18(4), 937-965.
- Krueger, R. A. (1988). *Focus groups: A practical guide for applied research*. London: Sage.
- Marks G., Solis J., Richardson J. L., Collins L. M., Birba L., & Hisserich J. C. (1987). Health behavior of elderly Hispanic women: Does cultural assimilation make a difference? *American Journal of Public Health*, 77(10), 1315-1319.
- Meyer, J., & Muntaner, C. (1999). Injuries in home health care workers: An analysis of occupational morbidity from a state compensation database. *American Journal of Industrial Medicine*, 35(3), 295-301.
- Mintzer, J. E., Rubert, M. P., Loewenstein, D., Gamez, E., Millor, A., Quinteros, R., Flores, L., Miller, M., Rainerman, A., & Eisdorfer, C. (1992). Daughters caregiving for Hispanic and non-Hispanic Alzheimer patients: Does ethnicity make a difference? *Community Mental Health Journal*, 28(4), 293-303.
- Morano, C. L., & Bravo, M. (2002). A psychoeducational model for Hispanic Alzheimer's disease caregivers. *Gerontologist*, 42(1), 122-126.
- Najera, L., & Heavey, B. (1997). Nursing strategies for preventing home health aide abuse. *Home Healthcare Nurse*, 15(11), 758-767.
- Navarro, V. (2002). *Bienestar insuficiente, democracia inacabada*. Madrid: Anagrama.
- Neysmith, S., & Aronson, J. (1997). Working conditions in home care: Negotiating race and class boundaries in gendered work. *International Journal of Health Services*, 27(3), 479-499.
- Piotrkowski, C. S. (1998). Gender harassment, job satisfaction, and distress among employed white and minority women. *Occupational Health Psychology*, 3(1), 33-43.
- Robinson, J. W., & Swanson, N. (2002). Psychological well-being of working women: A cross-cultural perspective. *Current Womens' Health Report*, 2(3), 214-218.
- Samaan, R. A. (2000). The influences of race, ethnicity, and poverty on the mental health of children. *Health Care for the Poor and Underserved*, 11(1), 100-110.
- Szasz, A. (1990). The labor impacts of policy changes in home care: How federal policy transformed home health organizations and their labor practices. *Journal of Health Politics, Policy and Law*, 15, 191-200.
- Soderfeldt, B., Soderfeldt, M., Muntaner, C., O'Campo, P., Warg L. E., & Ohlson, C. G. (1996). Psychosocial work environment in human service organizations: A conceptual analysis and development of the demand-control model. *Social Science and Medicine*, 42(9), 1217-1226.
- Stueve, A., Vine, P., & Struening, E. L. (1997). Perceived burden among caregivers of adults with serious mental illness: Comparison of black, Hispanic, and white families. *American Journal of Orthopsychiatry*, 67(2), 199-209.
- Weiler, R. M. (1998). Home health care workers' attitudes toward the elderly. *Home Health Care Services Quarterly*, 16(4), 1-13.

ACKNOWLEDGMENTS. We would like to dedicate this article to the memory of our late friend and colleague Marilu Camarena (SEIU) for her generous support, which made data collection possible. We also would like to thank the home care workers at SEIU 434B for their enthusiastic participation in the study, and Michelle Collins from New Perspectives for facilitating English focus groups.

OFFPRINTS. Requests for offprints should be directed to Jeanne Geiger-Brown, PhD, RN, University of Maryland School of Nursing, 655 West Lombard St., Baltimore, MD 21201. E-mail: jgbrown@son.umaryland.edu