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Development of a Caregiver Empowerment Model to Promote Positive Outcomes

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Abstract
Family members caring for aging parents experience both negative and positive outcomes from providing care. Theoretical explanations for negative outcomes have been developed. There is need for models that explain and predict positive outcomes. This article describes the evolution of the Caregiver Empowerment Model (CEM) to explain and predict positive outcomes of family caregiving. Although empirical findings support positive outcomes of family caregiving, less attention has been given to theoretical rationale for positive effects. The CEM predicts that, in the presence of filial values and certain background variables, caregiving demands are appraised as challenges instead of stressors. Appraising caregiving demands as a challenge, finding meaning, and using certain types of coping strategies are posited to be associated with growth and well-being. The CEM extends our understanding of the complexity of the caregiving experience, and can serve as a framework to guide in developing and testing theory-based interventions to promote positive outcomes.

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Introduction

Even though family members caring for elderly relatives experience stress and negative health outcomes (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995), some family caregivers find rewards in providing care (Andren & Elmstahl, 2005; Farberman et al., 2003; Pierce, Steiner, Govoni, Thompson, & Friedemann, 2007). Interviews with Chinese and Filipino American women filial caregivers (Jones, 1995, 1996; Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002; Jones, Zhang, & Meleis, 2003) indicated that although the caregivers faced multiple stressors, they reported more positive than negative outcomes. The women were challenged by the demands of multiple roles but rewarded by satisfaction from giving back to their parents in gratitude for what they had done for them. Their commitment to traditional values of respect and reciprocity influenced the way they managed their responsibilities, how they coped with the stressors and ultimately their health.

These findings from the study of Asian American women caring for aging parents are congruent with other empirical reports of positive outcomes from family caregiving in diverse cultural groups. More than a decade ago Farran and colleagues reported that African American and White caregivers of family members with dementia found meaning in the caregiving experience, and caregivers with higher levels of meaning had lower depression scores (Farran, Miller, Kaufman, & Davis, 1997; Farran, Miller, Kaufman, Donner, & Fogg, 1999). These observations are congruent with Folkman’s (1997) research on the co-occurrence of positive affect along with negative affect during acute and chronic stress, and on meaning-focused coping (Moskowitz, Folkman, Collette, & Vittinghoff, 1996). Although Moskowitz and colleagues studied AIDS caregivers, subsequent research has supported their observations with other stressors. For example, Fredrickson’s (1998) work showing the beneficial role of positive emotions in broadening and replenishing the person’s social, intellectual, and physical coping resources is consistent with Moskowitz et al.’s findings. The significance of meaning as a factor influencing coping and coping outcomes warrants attention in investigators’ efforts to promote caregiver well-being. Folkman’s (1997, 2008) revised stress and coping model provides for both a mediating and moderating impact of meaning-focused coping and positive emotions on appraisal and reappraisal.

Keywords
family caregivers, aging families, conceptual model, meaning-focused coping, positive outcomes, health promotion
of stressors and resources. These insights provide theoretical support for the creation of a model that can explain and predict outcomes of well-being in family caregivers.

Based on our own conceptual and empirical work, and its congruence with that of other scholars, we have developed the Caregiver Empowerment Model (CEM, see Figure 1) to guide practice and research with a goal of promoting positive outcomes in family caregivers. In this article we describe the theoretical and empirical foundations of the CEM, along with its potential to predict well-being in family caregivers. The model takes into account the background variables that influence the caregiving situation, cultural beliefs about responsibility for family caregiving, caregiving demands, the caregiver’s appraisal of the demands they are facing, and specific resources that can facilitate positive outcomes. Implications of the CEM for research and practice are discussed and directions for future studies are suggested.

**Theoretical Foundations of the Caregiver Empowerment Model**

The CEM is based primarily on two existing frameworks: (a) Jones and Meleis’ (1993) health empowerment model, which incorporates both Antonovsky’s
salutogenic theory of stress and Pearlin, Mullan, Semple, and Skaff’s (1990) caregiving stress process model, and (b) Folkman and Mosokvitz’s (2000a) theory of meaning-focused coping. Each of these frameworks adds insights to explain and predict positive outcomes from family caregiving. In the CEM, empowerment is defined as an increase in one’s ability to appraise, influence, and manage a situation using contextual and personal resources to achieve desired outcomes.

The Health Empowerment Model

The Health Empowerment Model (Jones & Meleis, 1993) evolved from several theoretical and interdisciplinary views of health for the purpose of promoting health in individuals who are exposed to ongoing stressful stimuli. This model influenced the CEM by contributing the proposition and theoretical support that, when stressors are present, personal, family, and community resources can empower the caregiver to manage the situation effectively and achieve positive health outcomes.

Regardless of one’s definition of health, it is acknowledged that some individuals emerge from an illness or stressful situation stronger and healthier than before rather than more vulnerable as might be expected. Some of the theories which have contributed to this view include Younger’s (1991) theory of mastery, Moch’s (1989) idea of the possibility of health-within-illness, and Jones and colleagues’ (2003) report of caregivers transforming vulnerability into well-being. Thus the CEM proposes that caregivers who are challenged to meet competing demands can be empowered for action and for health when personal and contextual (family and community) resources are available.

Antonovsky’s (1979) theory of a salutogenic (health generating) response to stress contributed to the development of the health empowerment model. The core construct of his theory, sense of coherence (SOC), is a pervasive and enduring feeling of confidence that one’s internal and external environments are predictable and that things will work out as well as can reasonably be expected. A variety of factors contribute to the development of a SOC. One factor is adaptability, which Antonovsky (1979) described as physiological, psychological, social, and cultural in nature. Others are meaningfulness, comprehensibility, and manageability (Antonovsky, 1987). Antonovsky explained that, where there is a strong sense of meaningfulness in a difficult situation it is likely the individual will see the experience as one “that can be coped with, and challenges that can be met” (p. 17).

Support for Antonovsky’s work includes studies by Kobasa (1979) and Maddi (2008) who addressed psychological hardiness; Dubos (1965) and Lerner
(1984) who focused on concepts of plasticity and adaptability; Craft’s (1999) study on feminine hardiness; and McCrae and Costa’s (1988) work on ego-resilience and psychological resilience. These constructs reflect similar understandings of how some individuals are able to endure prolonged stress without negative effects on their health. Hardiness, resilience, and SOC—all feature the human ability to manage difficult demands in ways that maintain and promote health. Hence they are a core part of the theoretical foundation of the health empowerment model. While these are not the only personal resources that contribute to positive outcomes and mediate the negative effects of stress but also they empower individuals to manage tension and engage effectively in problem solving, thus providing strong support for the CEM.

Pearlin and Schooler’s (1978) stress and coping process also contributed to the health empowerment model. Of particular importance is the significant role that background and contextual factors play in influencing which life experiences are stressful. All of these authors agree that given certain personal characteristics and resources, it is possible for human beings to do more than survive crises, and to actually grow stronger as a result of encountering stressors and demands. Antonovsky’s concept of SOC is consistent with the work of other scholars in this area: for example, Tedeschi and Calhoun (1995); Tedeschi, Park, and Calhoun, (1998); Rutter (1985); Strumpfer (1995); and Harvey (1996) all describe the remarkable ability of the human spirit to recover from insult and grow in ways that reflect healing, wisdom, and strength (Almedom, 2005). As the health empowerment model was built on these insights and integrates constructs that have the potential to explain and predict empowerment for health in individuals who are at risk, it provides a strong theoretical foundation for the CEM.

**Meaning-Focused Coping**

Lazarus and Folkman (1984) described coping with stress as beginning with appraisal (primary and secondary) and ending with reappraisal. Primary appraisal of an encounter leads to interpreting an experience as irrelevant, benign-positive, or stressful and, if stressful, involving harm/loss, threat, or challenge. Secondary appraisal involves assessment of the resources available for coping. Encounters that require resources beyond the individual’s ability to manage are considered as stressors. Reappraisal of both stressors and resources is very important; when reappraisal of one or both is positive, positive outcomes are facilitated (Lazarus & Folkman, 1984). The processes of appraisal and reappraisal allow for interpretation of the meaning and significance of the demands and challenges the caregiver is facing. When
appraised as deeply meaningful and important to an individual’s values and purposes, energy for coping expands empowering individuals to persist, survive, and grow. This is supported by the observations of other scholars who have found meaning to be an important variable influencing caregiving outcomes (Ayres, 2000; Farran et al., 1997; Hunt, 2003).

Current work by Folkman and colleagues (Folkman, 2008; Folkman & Moskowitz, 2004, 2007) acknowledge that coping is more complex than first thought. These authors and others suggest that there is a strong adaptive function in the use of positive psychological states to cope with stressors and manage distress. For example, finding meaning in an ongoing stressful encounter contributes to positive reappraisal and ultimately to positive outcomes. Similarly, revising one’s goals facilitates a sense of control and also helps restore psychological resources for coping.

An important piece of this complex interplay among concepts is the fit between the coping strategies used and the demands of the situation or “coping-environment fit” (Folkman & Moskowitz, 2004). This fit implies that the individual is able to modify his or her coping if necessary, and that there can be coping flexibility. Coping flexibility is congruent with the concept of adaptability (Antonovsky, 1979, 1987; Jones, 1991) and with the construct of psychological resilience (Tugade, Fredrickson, & Barrett, 2004).

Another piece of the complexity is the finding that positive and negative emotions co-occur (Folkman, 1997, 2008; Folkman & Greer, 2000; Folkman & Moskowitz, 2000a, 2004). In fact, studies support the possibility that positive affect in the midst of enduring stress serves as a buffer against adverse physiological consequences of stress and contributes to adaptation (Folkman & Moskowitz, 2000b). Fredrickson (1998) showed that positive emotions broaden the individual’s behavioral repertoire and replenish or build the person’s social, intellectual, and physical resources. Thus, it is now recognized that positive emotions and psychological resilience (Tugade et al., 2004) contribute to coping strength and health. These personal resources, along with access to family and community resources, empower the individual to manage the caregiving demands in a way that can be health generating (Mittelman, Roth, Haley, & Zarit, 2004).

**Empirical Foundations of the Caregiver Empowerment Model**

In addition to the theoretical foundations described above, our own empirical work along with that of other investigators led to development of the model (Figure 1). Each construct in the model functions as a significant variable
organized in a deliberate and meaningful pattern of interaction. Each has the potential to contribute to the process of empowerment.

Background

Potential background variables in the CEM include, but are not limited to, acculturation, demographics, and prior relationships. These variables are posited to directly influence caregiving demands, filial values, and use of resources. Research supports these proposed relationships. Acculturation is described in various ways, one of which is number of years in the U.S. Acculturation influences beliefs and values related to filial responsibility, as well as coping strategies and resources used to manage the caregiving (Hsueh, Hu, & Clarke-Ekong, 2008). A Swedish study of 156 family caregivers revealed that older caregivers expressed more satisfaction in caregiving than their younger counterparts (Andren & Elmstahl, 2005). African American caregivers have been found to express more positive aspects of caregiving than Caucasians (Hilgeman, Allen, DeCoster, & Burgio, 2007). The influence of demographic variables such as race or ethnicity have been found to be associated with resources (Hilgeman et al., 2009), while caregiver gender has been associated with attitudes and beliefs regarding filial values (Chappell & Kusch, 2007; Yoo & Kim, 2010). The nature of prior relationships may also influence the caregiver’s interaction with the care receiver and the type of care he or she will provide (Williamson & Shaffer, 2001; Yamashita & Amagai, 2008). Caregivers who are more distantly related to the care receiver have also been shown to express less satisfaction from caregiving than those who are more closely related (Andren & Elmstahl, 2005).

Filial Values

Filial values are attitudes and beliefs about responsibility for one’s aging parents. Beliefs and commitments to maintaining traditional values have been shown to influence caregiver motivation to provide care for aging parents. Such commitment has been examined and reported under different labels including filial obligations and responsibility, filial norms, filial piety, and others. There is beginning evidence across cultures that one’s filial beliefs and values not only influence caregivers’ motivation to provide care but also influence caregiver actions and outcomes as well (Cheng & Chan, 2006; Kao & Travis, 2005; Pang et al., 2002; Pierce, 2001). In Chinese culture, filial values are based on beliefs about filial piety, called Hsiao, which are rooted in Confucianism and recognized as nearly
sacred. Although perceived partly as an obligation, caregiving is also regarded as an opportunity to show appreciation for “the gift of life” and to pay back the love and generosity received during childhood. This represents reciprocity between generations. Reciprocity is a core virtue in Chinese culture, but is not unique or limited to Asian culture. It is a core concept in Western social science theories that explain responsibility of adult children for aging parents. Social exchange theory and equity theory are examples (Adams, Berkowitz, & Hatfield, 1976; Homans, 1961). In the context of families, whether it be social exchange or equity, reciprocity is central.

Jones, Lee, and Zhang (2007) developed and tested a scale to measure filial values. Exploratory factor analysis identified three dimensions to the scale: (a) a sense of responsibility for parents, (b) respect and admiration for parents, and (c) a desire to care for parents. This was validated through confirmatory analysis. In the CEM it is proposed that filial values may (a) change how the individual appraises caregiving demands—that is, as challenges instead of stressors, (b) contribute to the resources available for coping through the strong sense of purpose and meaning associated with giving back to one’s parents, (c) influence access to family resources and use of community resources, and (d) indirectly influence outcomes through resources and appraisal.

**Caregiving Demands**

Examples of caregiving demands include care-receiver impairment, the caregiving activities, and competing role demands. There is ample evidence of the negative impact of caregiving demands on the life and health of caregivers (Aneshensel et al., 1995; Faison, Faria, & Frank, 1999; Stephens, Townsend, Martire, & Druley, 2001). For some caregivers such demands are clearly experienced as stressors with all the consequences of exposure to prolonged stress. In contrast when caregivers identify uplifts in caregiving, these uplifts are associated with caregiver subjective well-being (Pinquart & Sorensen, 2004). In the CEM it is suggested that when filial values are present, and when certain resources are available, the caregiver is likely to appraise the demands as meaningful challenges (Kobasa, 1979), as salutogenic instead of pathogenic (Antonovsky, 1987), and as a stimulus for personal growth. The consequences of such appraisal are likely to be positive rather than negative, which is a conceptual difference between Pearlin’s (Pearlin, 1989; Pearlin et al., 1990; Pearlin, Lieberman, Menaghan, & Mullan, 1981) caregiver stress process model and the CEM.
Resources

Resources are factors that help support positive appraisal of caregiving demands and facilitate effective coping and management of care. Some are interpersonal resources such as coherence and spirituality, and some are external or contextual, such as family support or community resources. In the CEM resources can have a direct effect on outcomes and an indirect effect through the influence of appraisal on outcomes (Baron & Kenny, 1986; Kraemer, Wilson, Fairburn, & Agras, 2002). Although much of the research evaluating the effectiveness of community resources in reducing caregiving burden has shown minimal effects, studies in which clients and/or their families received timely and adequate amounts of help have shown more positive outcomes (Santo, Scharlach, Nielsen, & Fox, 2007; Zarit, Gaugler, & Jarrott, 1999). In addition to timeliness and adequacy of community services, studies also suggest that these services must be culturally appropriate (Li, 2004). When services are accessible, timely, and appropriate, it is suggested that they will positively influence outcomes. Similarly, when personal resources of coherence and spirituality are present and when family connectedness exists, appraisal of caregiving demands as challenges may actually enhance perceived health, stimulate personal growth, and promote existential well-being (Jones et al., 2003). On the other hand, when such resources are lacking, caregiving demands may be perceived as stressors, and detrimental to health, growth, and well-being (Aneshensel et al., 1995). Depending on cultural values, particularly filial values, use of community resources will vary greatly because in some cultural groups accepting assistance from outside the family is seen as an insult to their parents and to be done only as a last resort (Jones et al., 2002).

Based on the relationships between the constructs in the CEM it could be hypothesized that caregivers who are committed to caregiving, who view their caregiving responsibility as a meaningful challenge, and are psychologically resilient are likely to manage caregiving demands effectively leading to positive health outcomes.

Appraisal

Appraisal is subjective assessment of the presence and level of threat to well-being, or of the challenges faced, and of the resources available to manage the challenge. It is posited to be directly influenced by caregiving demands, filial values, and personal, family and community resources. These proposed
relationships are supported by the findings in Jones et al.’s (2002, 2003) study of immigrant Chinese and Filipino American women caregivers of aging parents. Using a grounded theory approach (Strauss & Corbin, 1990), this qualitative study of 41 Asian American women revealed two substantive social processes. These processes were (a) transforming vulnerability (Jones et al., 2003) and (b) caregiving between two cultures (Jones et al., 2002).

Transforming vulnerability refers to the experience of increased risk that the caregivers described, and the coping strategies developed that led to positive outcomes. Limited availability and use of community support contributed to their vulnerability. Cultural beliefs about family versus community responsibility interfered with accessing such assistance. For some, the stress of caregiving resulted in difficulty sleeping, hypertension, and other indications of compromised well-being. However, a sincere sense of gratitude toward their parents and a desire to give back were intricately intertwined with feelings of obligation and responsibility. Most participants became more determined to “do whatever it takes” because it was so important to them. The meaning derived from fulfilling their obligation brought great satisfaction. The strategies they developed to overcome increased risk included (a) connecting with their deeply held values, (b) integrating the caregiving role into the fullest meaning of who they are, and (c) mobilizing resources—particularly personal and family resources. While the caregiving demands and stressors encountered will vary according to cultural group, the coping strategies developed by these caregivers are not unique to Asian culture. Caregivers from other groups also report personal and spiritual growth from the caregiving experience (Andren & Elmstahl, 2005; Hilgeman et al., 2007; Picot, Debanne, Namazi, & Wykle, 1997).

Caregiving between two cultures reflects the challenge the caregivers experienced as they struggled to integrate two sets of cultural values. The women had strong beliefs of filial responsibility, were deeply committed to caring for their aging parents and to maintaining traditional values. They perceived their caregiving responsibility as a challenge rather than a stressor, and as a way to give back to their parents. Therefore, their experience was infused with meaning. The women developed personal resources (coherence, endurance, and spirituality) and drew on family resources (family connectedness and assistance from family members) to manage the challenge and preserve well-being. Thus in spite of the lack of culturally appropriate support services and limited or no use of community resources, the caregivers persisted in the caregiving role and ultimately described outcomes of personal growth, meaning, and integration. Although caregivers in other cultural groups may not be struggling with being in two cultures, traditional and contemporary values are present in any group with tension between the two.
Outcomes

Outcomes are defined as changes in caregiver health and well-being as a consequence of participating in the caregiver role. A unique element of the CEM is its focus on positive outcomes of the caregiving process. Although there will be variability in the consequences of how one manages the caregiving demands, in the CEM there is a possibility of positive outcomes. The model suggests that in the presence of filial values, demands are perceived as challenges, and when personal, family, and community resources are accessed the caregiver has the potential to experience enhanced well-being in both physical and mental health, personal growth, and existential well-being. Literature has shown that appraising stress as a challenge, being able to create meaning for it, and using certain types of coping appear to be associated with growth (Park, 1998).

Implications for Nursing Research and Practice

Although there have been empirical findings supporting positive outcomes of family caregiving, less attention has been given to theoretical or conceptual frameworks in providing rationale for positive effects. The quality of the prior child–adult relationship has been suggested as a predictor of how caregiving responsibility is perceived and accepted (Williamson & Shaffer, 2001). Theories such as role attainment and attachment have been used to explain caregiver reward (Lee, 2007). Acculturation and social exchange variables have been tested as predictors of parental expectations for filial piety (Kao & Travis, 2005). Conceptualization of social exchange that includes aspects of reciprocity, repaying, obligation, and implicit cultural exchange has also been supported through qualitative research (Hsu & Shyu, 2003). Testing of a theoretical model by Carruth and colleagues was reported to show that family satisfaction in elder caregiving was predicted by a sense of reciprocity, emotional well-being, and positive family functioning (Carruth, Tate, Moffett, & Hill, 1997).

Despite these studies that have included theoretical underpinnings, most of the literature explaining positive caregiver outcomes does not have the same depth of theoretical consideration that can be found when looking at the negative outcomes. Models such as the Stress Process (Pearlin, 1989; Pearlin et al., 1981, 1990) and Stress and Coping (Lazarus & Folkman, 1984) have provided convincing rationale for understanding the stressful outcomes of caregiving. If we are to understand the family caregiving experience in its many facets, theoretical understandings of positive outcomes are also needed.
In this article we have drawn together theoretical and research findings and have posited a heuristic model that suggests potential pathways for predicting caregiver empowerment. The CEM was developed to help explain and predict positive outcomes of filial caregiving. It is presented here as a framework to guide in developing and testing interventions to promote these outcomes. Such interventions may focus on one or more of the variables in the model. For example, interventions focused on finding meaning through fulfillment of filial values, promotion of positive appraisal and positive coping, development of personal resources and accessing family, and community resources could facilitate positive outcomes. Given current changes in the health care environment and an aging society, there will undoubtedly be greater demand for filial caregiving in the future and for promotion of positive caregiver health outcomes.

We suggest that researchers move beyond describing the relationships between predictor variables and caregiving outcomes to testing and refining theoretical models to extend our understanding of the complexity of the caregiving experience. Studies could be designed to test portions of the model presented in this article. For example, researchers might choose to test whether filial values mediate the influence of background variables on caregiver appraisal and/or use of resources (Baron & Kenny, 1986; Kraemer et al., 2002). Studies could also examine the potential direct relationship of resources on appraisal and whether the effects of resources on outcomes are also mediated through appraisal. Additional research could be directed at whether the influence of caregiving demands is wholly mediated through appraisal, as suggested in the CEM, or whether caregiver demands also have direct effects on caregiver outcomes. Ultimately, with an adequate sample, structural equation modeling could be used to test the multiple direct and indirect pathways suggested by the model. It is anticipated that, with adequate research, this model would be revised and provide a more complete explanation of variables that influence caregiver well-being.

By focusing research efforts on understanding why some families experience positive outcomes from caregiving we will have evidence for the development of supportive interventions. It is our conviction that interventions targeted toward empowering the family caregiver will result in reduced caregiver stress and lead to more positive outcomes for caregivers and their family members. Revisioning family caregiving through an empowerment framework will guide health professionals in promoting caregiver well-being and lead to new opportunities to partner with families in meeting the challenges of community-based elder care.
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