J Immigrant Minority Health
DOI 10.1007/s10903-012-9700-9

ORIGINAL PAPER

Leveraging Family Values to Decrease Unhealthy Alcohol Use in Aging Latino Day Laborers

Homero E. del Pino · Carolyn Méndez-Luck · Georgiana Bostean · Karina Ramírez · Marlom Portillo · Alison A. Moore

Abstract In one Los Angeles study, 20 % of day laborers reported excessive drinking. Older adults are more sensitive to alcohol's effects, yet heavy drinking persists among Latinos until they are in their 60s. No interventions to reduce heavy drinking exist for aging day laborers. We recruited 14 day laborers aged 50 and older in Los Angeles. We identified their unhealthy alcohol use behaviors and comorbidities and conducted semi-structured interviews to understand their perceptions of unhealthy alcohol use. We found social disadvantages and conditions exacerbated by alcohol use, like depression. Participants were concerned with dying and premature aging, and reported that family could influence behavior change. An intervention should consider (1) integrating family values and (2) increasing knowledge about alcohol use and comorbidities. Further studies are needed to explore family influence on aging Latino day laborers.

Keywords Latino · Day laborers · Alcohol abuse · Family values

H. E. del Pino (✉)
Department of Psychiatry and Human Behavior, Charles R. Drew University of Medicine and Science, 1731 E. 120th St., Building N, Los Angles, CA 90059, USA
e-mail: homerodelpino@cdrewu.edu

H. E. del Pino
Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, UCLA, Los Angeles, CA, USA

C. Méndez-Luck
School of Social and Behavioral Health Sciences, Oregon State University, Corvallis, Corvallis, OR, USA

G. Bostean
Cancer Prevention and Control Research, UCLA Fielding School of Public Health, Los Angeles, CA, USA

K. Ramírez · A. A. Moore
Division of Geriatrics, David Geffen School of Medicine, UCLA, Los Angeles, CA, USA

M. Portillo
Instituto de Educación Popular del Sur de California, Los Angeles, CA, USA

Introduction

Heavy drinking in aging Latino day laborers creates conditions for negative health outcomes. "Day labor" is often characterized as work done primarily by men who congregate in street corners or in front of businesses like Home Depot [1]. In the United States, there are an estimated 117,647 day laborers on any given day, of whom 91 % are immigrant Latinos [2]. Studies show that people who experience social disadvantage are likely to engage in unhealthy alcohol use behaviors and experience related health problems [3]. Day laborers are largely socially disadvantaged: among 479 day laborers surveyed in Los Angeles in 2001, 95 % were undocumented; 85 % had less than a high school education; and 84 % had limited English proficiency; [4] and a 2010 survey of 1,815 Latino day laborers in Los Angeles found that almost 30 % of the workers experienced violations of minimum wage laws in the workweek preceding the survey [5]. Also, some day laborers engage in heavy drinking: among day laborers in Los Angeles, 20 % reported ever being an excessive drinker, with 15 % reporting drinking more than seven drinks daily and 26 % reporting drinking a fifth of liquor (25 oz.) in 1 day [5]. This level of drinking is categorized as heavy drinking by the National Institute on Alcohol Abuse and Alcoholism: for men it is more than four drinks in 1 day or more than 14 in 1 week [6].

Published online: 09 August 2012

Heavy drinking persists in Latinos until they are in their 60s [7, 8], while drinking, and particularly heavy drinking, declines with increasing age in Whites [9]. Although Whites have higher rates of alcohol abuse and dependency than Latinos [10], compared to other ethnic groups, Latinos have higher rates of health conditions associated with alcohol abuse: cancer, unintentional injuries, and chronic liver disease/cirrhosis [11], which are often comorbid with depression and anxiety [12]. Latinos often engage in a pattern of low frequency, high levels of drinking per occasion, unlike Latinas who are usually abstinent or low-level drinkers [13] and US-born Latinos have higher rates of alcohol abuse than foreign-born Latinos [14].

Yet, to our knowledge, there have been no studies testing interventions to reduce heavy drinking among aging Latinos, particularly aging day laborers. Of the more than 40 randomized trials examining interventions to reduce heavy drinking among younger adults in primary care sites [15], only one targeted Mexican–Americans [16], and three targeted older, primarily White adults [17–19].

We conducted semi-structured interviews to understand unhealthy alcohol use behaviors in socially disadvantaged, middle-aged and older Latino day laborers. We asked questions to explore their beliefs about the consequences of their alcohol use and what, if anything, would motivate them to change their drinking habits in order to identify elements for a culturally- and age-appropriate intervention.

Methods

This study used a grounded theory approach to explore how views of drinking behaviors were socially constructed by Latino day laborers. We used semi-structured interviews which can be especially effective in revealing the emotional and the symbolic meanings of drinking and its consequences that are not detected in typical survey approaches [20].

Participants

We recruited participants from a job center operated by the instituto de educación popular del sur de California (IDEPSCA), a community-based organization that operates job centers and has a workers health project to address the health needs of day laborers in Los Angeles. The research team distributed flyers and presented at the job center to recruit participants. Some participants referred their friends. The inclusion criteria were being: (1) Latino; (2) a day laborer; (3) age 50 years or older; and (4) an unhealthy drinker (defined as someone who reported having had at least two alcoholic drinks daily or almost daily). The interviews were conducted at locations convenient for participants, like the job center or a nearby coffee shop. Interviewers obtained participants' permission to audio-record the interviews, which were conducted in Spanish and translated into English by a transcription service. Participants each received a $25 gift card for participating in the study.

Data Collection

The institutional review board at the University of California, Los Angeles approved all study materials and procedures. Between January 20, 2009 and April 2, 2009, trained Spanish-speaking interviewers conducted semi-structured, face-to-face interviews lasting approximately 1 h. Interviewers asked participants about (1) their perceptions of the health consequences of drinking alcohol (e.g. What do you think happens to your body when you drink alcohol?); (2) facilitators and barriers for changing their drinking behaviors (e.g. Would anything make you want to change your drinking habits?); and (3) their feelings about talking with health educators about their drinking habits (e.g. How comfortable would you be talking about your drinking behavior with a health educator?). Participants also completed a questionnaire with information on demographic characteristics (age, birth country, marital status) and health (family history of diabetes mellitus, high blood pressure). Alcohol use was measured using the comorbidity-alcohol risk evaluation tool (CARET) [18, 21], which is used to identify adults who are unhealthy drinkers by assessing amount of alcohol use, comorbidity, symptoms and medication use [22–24].

Data Analysis

We calculated descriptive statistics for the quantitative data. Transcripts were entered into Atlas.ti, a data management program for qualitative data. Interviews were interpreted through an inductive and data-driven, grounded theory approach [25, 26] that involved an iterative process of taxonomic organization, content analyses, and code mapping. Transcripts were coded during repeated examinations of the text by the multidisciplinary research team. The text was first broken down into fragments and "clustered" around single words or phrases. Clusters of text were coded and organized into a hierarchy of categories at consecutively higher levels of abstraction to build thematic content. We employed a constructivist paradigm in which the findings were "created" by exploiting the "variable and personal" nature of social constructs to refine individual constructs by comparing and contrasting them [27]. We used pseudonyms to de-identify the data.

Table 1 Socio-demographic and health-related characteristics (n = 14)

Characteristics	Total n (%)[a]
Age in years, mean (range)	53.6 (50–s65)
Where were you born?	
Guatemala	2 (14.3)
Mexico	12 (85.7)
Marital status	
Married	4 (28.6)
Divorced/separated	6 (42.9)
Never married	4 (28.6)
Living situation	
Living with spouse	1 (7.1)
Living with partner	5 (35.7)
Living with relatives or friends	2 (14.3)
Living with others, not relatives or friends	5 (35.7)
Live alone	1 (7.1)
Education[b]	
≤8th Grade	5 (38.5)
Some high school	6 (46.2)
High school graduate/GED[c]	1 (7.7)
Technical/trade school	1 (7.7)
Employment	
Working part-time	14 (100)
Annual income	
<$5,000	13 (92.9)
$5,000–$14,999	1 (7.1)
Year moved to the United States	
Before 2000	12 (85.7)
2000 and thereafter	2 (14.3)
Understand English	
Very well	2 (14.3)
Not too well	7 (50)
Not at all	3 (21.4)
Don't know	2 (14.3)
Speak English	
Very well	2 (14.3)
Not too well	6 (40.0)
Not at all	3 (21.4)
Don't know	3 (21.4)
Read English	
Very well	2 (14.3)
Not too well	2 (14.3)
Not at all	5 (35.7)
Don't know	4 (28.6)
Family history of…	
Depression	6 (42.9)
Alcohol problems	12 (85.7)
Current health status	
Excellent	0 (0)
Good	2 (14.3)
Fair	8 (57.14)
Poor	4 (28.57)
Quality of Life (scale 0–10)	
0–6 (worse)	8 (57.1)
7–10	6 (42.9)

[a] Total may not add up to 100 % due to rounding

[b] One response is missing for education

[c] General educational development test

Results

Sample Characteristics

Fourteen day laborers completed interviews. Table 1 shows that the respondents ranged in age between 50 and 64 years; the majority was from Mexico, lived with people other than their family members, and had less than a high school level education. All worked part-time and all but one reported earning <$5,000 each year. Most had lived in the US for at least 10 years, reported understanding or speaking English, and few reported being able to read English at any level. Almost all the participants reported a family history of alcohol abuse and rated their current health status as fair or poor. Thirteen of the 14 participants completed the CARET, and all reported drinking 4–7 or more drinks per occasion in frequencies ranging from 2–4 times per month to 6–7 times per week (Table 2). Participants reported multiple symptoms and conditions that could be caused or worsened by alcohol, including feeling sad or blue, trouble sleeping, and hypertension.

Thematic Analysis

In our analysis of the participants' answers, three primary themes emerged: (1) perceived consequences of unhealthy alcohol use on physical and mental health (2) the impact of unhealthy alcohol use on family relationships, and (3) the family as a key factor in efforts to change behavior (Table 3).

Consequences of Unhealthy Alcohol Use on Physical Health

Participants reported negative consequences of unhealthy alcohol use, including blackouts, accidents, job loss, falling due to loss of balance, cerebral hemorrhages, and epileptic convulsions. Respondents reported concerns with dying or aging faster. Two participants illustrated these concerns

Table 2 Alcohol use, symptoms and conditions (n = 13)[a]

Items	Total n (%)[b]
Frequency of drinking	
6–7 times per week	1 (7.7)
4–5 times per week	3 (23.0)
2–3 times per week	5 (38.5)
Once a week	2 (15.4)
2–4 times per month	2 (15.4)
Quantity of drinking per occasion	
7 or more drinks	8 (61.5)
Sometimes or often have the following symptoms:	
Feeling sad or blue	9 (69.2)
Trouble sleeping	6 (46.2)
Gastrointestinal complaints	5 (38.5)
Memory problems	5 (38.5)
Conditions	
Hypertension	5 (38.5)
Diabetes mellitus	2 (15.4)
Depression	3 (23.1)
Gout	2 (15.4)

[a] One response is missing

[b] Total may not add up to 100 % due to rounding

Table 3 Themes regarding consequences and impact of unhealthy alcohol use

Perceived consequences of unhealthy alcohol use on…
Physical health
Alcohol use will lead to new disease or death in the future
Alcohol impacts health today
Mental health
Alcohol seen as a way to cope with depression and loneliness
Will come to believe that no one loves him
Impact of alcohol on family relationships
Children and extended family suffer more than the alcohol user realizes
Family has cut-off the alcohol user
Family values and assistance for behavior change
Restoring relationships with spouses and children most important
Health educators that treated men like family, e.g., caring, worrying about safety

and the normalcy of heavy drinking. Diego, a 56 year-old diabetic Mexican who consumed one to two beers with dinner and 10–15 beers on Saturdays, claimed that being a heavy drinker was hereditary. "[Alcoholism] runs in the family. My father died of cirrhosis…. It's in us. We like [alcohol]. We can't stay away."

Similarly, Gabriel, a 50 year-old Mexican, reported depressive symptoms and numerous falls in the past 12 months. He consumed seven or more drinks daily. He had been warned of his risk for cirrhosis, yet indicated that he needed to drink to start his day, because "…I get palpitations in my stomach, like ulcers, and it prevents me from eating. I have to drink one [beer] to eat; otherwise I can't eat. [Eating] makes me vomit." He talked about friends that died because of excessive drinking and not eating enough:

> [Many] would go for 15 days drinking without eating. Then they would die; they would have a heart attack …. A lot of them had cirrhosis also. They would vomit their liver and would bleed …

Excerpts from two other interviews also illustrated the concern with premature death:

> As long as I don't get any help … I'm not going to make it and I'll end up dead.
> Alcohol is one of those things that shortens everyone's lives.

These passages suggest that perceptions of the consequences of drinking were reinforced either by their own experiences or those of heavy drinkers they knew.

The Consequences of Unhealthy Alcohol Use on Mental Health

Many participants attributed their alcohol use to loneliness, depression, or lack of self-love. Andrés was 50 years old, had a history of epileptic convulsions, drank four drinks 2–3 days per week. He admitted that his "number 1 reason" for drinking was because his family was very far away and he "lives like a lonely dog in the street." Andrés shared that.

> … [I'm] facing depression, which is not a justification but the root of the problem … you want to get rid of your depression and you decide to go for a beer or 3 or 4 …. I have emotional problems and depression and precisely because of that [I] look for those vices in order not to feel it so much …

Other study participants indicated that, "depression is something to fight everyday," and "… the alcoholic uses because nobody loves him…."

The Impact of Unhealthy Alcohol Use on Family Relationships

For most participants, prolonged and heavy alcohol use had strained their immediate and extended family relationships and interfered with their ability to send money to their families still living in their native countries. Oscar, a 51 year-old Guatemalan, consumed four drinks, 2–3 times per week, and was homeless. His right hand had been amputated following a car accident in which he was drinking and driving. He reported that.

> … the family suffers the most and the kids suffer too, they all suffer more than us … but there's also an extended family, cousins, nephews, brothers, all of them … we're taking the family down with us.

Another participant explained that "little by little you don't belong to society or to your family." These selections were illustrative of the emotional pain experienced by both the families and the participants.

The Family as a Key Factor in Efforts to Change Behavior

The third theme that emerged was that family relationships are perceived as a source of motivation to stop or reduce drinking. Oscar, discussed earlier, described his alcoholism as "a nightmare that's never going to end" until he's dead, but, "I'd like to continue living because I still love my children and I… need this help, otherwise I'm going to [die]." He said that professional help would motivate him to reduce his drinking, but "most importantly, my family… [I don't want to] make my children suffer." Similarly, 50 year-old Juan, who reported having 12 drinks every Saturday and as well as trouble sleeping, memory problems, and feeling sad, believed that his family could motivate him to change his drinking behavior: "I [once] stopped doing cocaine because of my mother."

We also found that health educators perceived as fictive kin could also motivate participants to reduce their drinking. Participants reported being willing to meet with a health educator once a week or once a month and they often used language employed in the context of talking about their families. Andrés, discussed earlier, said, "[We must be] made to feel like family. I'm [health educator] here to help you, not to turn you into immigration. I'm your ally." Believing that health educators cared "…is something you need [so] you don't feel so alone." Ramón, a 64 years old Mexican with diabetes and problems falling asleep, reported that he consumed 7 or more drinks per day, four to five times per week. He also saw the health educators as fictive kin:

> [The health educators are] [w]onderful because only someone who loves you a lot or someone in your family would [help you] …. It makes you feel good that someone is worried about you… especially not having our family here … the support of someone else that worries about you … is a good stimulus.

Discussion

Our study of Latino day laborers has three main findings: (1) economic and social disadvantages; (2) unhealthy alcohol use and cumulative risk of heavy drinking and aging; and (3) strained family relationships and the perception that one's family could motivate behavior change. The study sample was socially disadvantaged, impoverished, poorly educated and virtually illiterate in English. They reported high levels of alcohol consumption; alcohol-related symptoms and conditions exacerbated by alcohol use; and framed the consequences of their drinking in the severest of terms—death. We found that drinking escalated in response to the pressures of immigrating and being away from family, which suggests they may need additional support. All the participants reported negative experiences with their families due to their alcohol use. Participants also reported being open to meeting regularly with a health educator.

Although the average age of the participants was 54 years, their drinking patterns and comorbidities are consistent with studies showing that heavy drinking in Latino men does not decrease until they are in their 60s [7, 8]. Research shows that older men with comorbidities and unhealthy alcohol use have a higher mortality rate than those who do not engage in unhealthy alcohol use, hence a lower threshold for what is considered unhealthy alcohol use may be appropriate for this population to reduce their mortality risk [28]. We infer from participants' concerns with premature aging and death that an intervention should increase their knowledge of alcohol use and comorbidities.

Further, the strain on family relationships caused by drinking may affect older laborers more acutely than younger ones. Physically, those with strained family ties may be less likely to have family members care for them as they age. Emotionally, negative feelings associated with failing to fulfill their expected social roles, like the provider for the family, might exacerbate feelings of guilt and shame and fuel drinking. Chronic access-to-care challenges or no health insurance, and physically demanding and dangerous jobs, make it likely that they will rely on informal care from the very family they alienated.

The most striking findings were the salience and motivational power the participants attributed to their families. The men believed that their families could help them more than a professional could. Every respondent prioritized their families over themselves when they discussed the consequences of alcohol use. Their answers were consistent with research demonstrating that Latinos often choose health behaviors in order to "do right" by the family; [29] that feelings of obligation to family influence behavior regardless of how long a person has resided in the United States; [30] and that there is a high reliance on family for emotional support [31]. This finding is also consistent with research showing that families play a greater role in men's decision to become sober as they age [32]. Alcohol abuse interventions based on family relationships have been developed already for Latino adolescentes [33, 34], but not

for middle-aged or older men. For men separated from their families, we suggest incorporating how they describe their families into the training of staff. Training program staff, like community health workers, can increase the success of an alcohol intervention program. Studies have demonstrated that health interventions that included community health workers were successful, including a program for Latinos with diabetes mellitus that had an 80 % completion rate; [35] culturally responsive curricula for farm workers [36], and reaching immigrant communities to enhance disease prevention and health promotion activities, as well as to improve access to healthcare services [37, 38]. Incorporating family values into the training of staff has the potential to offset the disruptions in family networks associated with substance use disorders in Latino men [39]. In addition, better understanding of Latino day laborers' family values can help to develop programmatic and social support networks that function as family proxies [40].

Limitations

The limitations of this study, like for all qualitative studies, include the small sample size, convenience sampling from one location, and its exclusive focus on males. Thus, the results may not capture the perspectives of other groups. Still, the findings provide a new way to think about Latinos' family values as constituents for an intervention.

New Contribution to the Literature

This study attempts to bridge the gap in research on unhealthy drinking among aging Latino day laborers. Our findings suggest participants' family values can be leveraged in an intervention. We also identified areas for further research: (1) exploring how family relationships motivate behavior change; (2) learning to integrate participants' family values into staff trainings; and (3) developing novel ways to disseminate information on unhealthy alcohol use, aging, and comorbidities within the context of immigrant and work experiences. Knowledge in these areas is needed to create elements for an intervention to reduce the burden of alcohol-related physical, emotional, and social consequences in this vulnerable population.

Acknowledgments Research supported in part by 1 K24 AA015957-05 and 1 R21 AA019738-01A1 from the National Institute on Alcohol Abuse and Alcoholism; RCMAR/CHIME Grant P30AG021684 and 1K01AG033122-01A1 from the National Institute on Aging; U54MD007598 (formerly U54RR026138) from the National Institute on Minority Health and Health Disparities; and the UCLA Career Development Program in Cancer Prevention and Control Research, NIH/NCI R25CA087949 (PI: R. Bastani).

References

1. UCLA Center for the Study of Urban Poverty. Day labor centers and community outcomes. http://www.csup.ucla.edu/publications. Accessed 12 Sep 2011.
2. Valenzuela A, Theodore N, Melendez E, et al. On the corner: day labor in the United States. Social Sciences,UCLA College of Letters and Science 2006. p. 1–34.
3. Mulia N, Ye Y, Zemore SE, Greenfield TK. Social disadvantage, stress, and alcohol use among black, Hispanic, and white Americans: findings from the 2005 US national alcohol survey. J Stud Alcohol Drugs. 2008;69(6):824–33.
4. Valenzuela A. Working on the margins in metropolitan Los Angeles: immigrants in day labor work. Migracinoes Int. 2002;1(2):5–28.
5. UCLA Institute for Research on Labor and Employment. Wage theft and workplace violations in Los Angeles—the failure of employment and labor law for low-wage workers. http://www.csup.ucla.edu/publications. Accessed 2 Jan 2012.
6. http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking. Accessed 14 July 2012.
7. Caetano R, Ramisetty-Mikler S, Rodriguez LA. The Hispanic Americans baseline alcohol survey (HABLAS): rates and predictors of alcohol abuse and dependence across Hispanic national groups. J Stud Alcohol Drugs. 2008;69(3):441–8.
8. Caetano R, Ramisetty-Mikler S, Rodriguez LA. The Hispanic Americans baseline alcohol survey (HABLAS): the association between birthplace, acculturation and alcohol abuse and dependence across Hispanic national groups. Drug Alcohol Depend. 2009;99(1–3):215–21.
9. Karlamangla AS, Sarkisian CA, Kado DM, et al. Light to moderate alcohol consumption and disability: benefits vary by health status. Am J Epidemiol. 2009;169:96–104.
10. Grant BF, Stinson FS, Hasin DS, Dawson DA, Chou SP, Anderson K. Immigration and lifetime prevalence of DSM-IV psychiatric disorders among Mexican Americans and non-hispanic whites in the United States: results from the national epidemiologic survey on alcohol and related conditions. Arch Gen Psychiatry. 2004;61(12):1226–33.
11. National Center for Health Statistics, CDC. Available: http://www.cdc.gov/omhd/populations/HL/HL/htm—Statistics.
12. Vega WA, Sribney WM, Achara-Abrahams I. Co-occurring alcohol, drug, and other psychiatric disorders among Mexican-origin people in the United States. Am J Public Health. 2003;93(7):1057–64.
13. Alvarez LR, Ruiz P. Substance abuse in the Mexican American population. In: Straussner SLA editor. Ethnocultural factors in substance abuse treatment. New York: The Guildford Press; 2001.
14. Szlafarski M, Cubbins LA, Ying J. Epidemiology of alcohol abuse among U.S. Immigrant populations. J Immigrant Minor Health. 2011;13:647–58.
15. Babor TF, Higgens-Biddle JC. Alcohol screening and brief intervention: dissemination strategies for medical practice and public health. Addiction. 2000;95:677–86.
16. Burge SK, Amodei N, Elkin B, Catala S, Andrew SR, Lane PA, Seale JP. An evaluation of two primary care interventions for alcohol abuse among Mexican-American patients. Addiction. 1997;92:1705–16.
17. Fleming M, Manwell L, Barry K, Adams W. Brief physician advice for alcohol problems in older adults: a randomized community-based trial. J Family Pract. 1999;48:378–84.
18. Moore AA, Blow FC, Hoffing M, et al. Primary care-based intervention to reduce at-risk drinking in older adults: a randomized controlled trial. Addiction. 2011;106(1):111–20.

19. Fink A, Elliott MN, Tsai M, et al. An evaluation of an intervention to assist primary care physicians in screening and educating older patients who use alcohol. J Am Geriatr Soc. 2005;53(11):1937–43.
20. Blieszner R, Hamon RK. Filial responsibility: attitudes, motivators, and behaviors. In: Dwyer JW, Coward RT, editors. Gender, families, and elder care. Newbury Park CA: Sage; 1992. p. 105–19.
21. Moore AA, Beck JC, Babor TF, et al. Beyond alcoholism: identifying older, at risk drinkers in primary care. J Stud Alcohol. 2002;63:316–24.
22. Moore AA, Seeman T, Morgenstern H, et al. Are there differences between older persons who screen positive on the CAGE questionnaire and the short Michigan alcoholism screening test-geriatric version? J Am Geriatr Soc. 2002;50(5):858–62.
23. Fink A, Tsai MC, Hays RD, et al. Comparing the alcohol-related problems survey (ARPS) to traditional alcohol screening measures in elderly outpatients. Arch Gerontol Geriatr. 2002;34(1): 55–78.
24. Moore AA, Hays RD, Reuben DB, et al. Using a criterion standard to validate the alcohol-related problems survey (ARPS): a screening measure to identify harmful and hazardous drinking in older persons. Aging (Milano). 2000;12(3):221–7.
25. Glaser BG, Strauss AL. The discovery of grounded theory: strategies for qualitative research. Chicago: Aldine; 1967.
26. Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. Thousand Oaks: Sage Publications; 2006.
27. Guba EG, Lincoln YS. Competing paradigms in qualitative research. In: Denzin NK, Lincoln YS, editors. Handbook of qualitative research. Newbury Park, CA: Sage Publications; 1993. p. 105–17.
28. Moore AA, Giuli L, Gould R, et al. Alcohol use, comorbidity, and mortality. J Am Geriatr Soc. 2006;54(5):757–62.
29. Davila YR, Reifsnider E, Pecina I. Familismo: influence on Hispanic health behaviors. Appl Nurs Res. 2010.
30. Santiago-Rivera AL. Latinos, value, and family transitions: practical considerations for counseling. J Couns Human Dev. 2003;35:1–12.
31. Marin G, Marin BV. Research with Hispanic populations. Newbury Park, CA: Sage; 1991.
32. Henges Larry N. The lived experiences of older adults who abuse alcohol: Why and how they became sober. Diss Abstr Int Sect A Humanities Soc Sci. 2008;68(11-A):4615.
33. Marsiglia FF, Kulis S, Parsai M, et al. Cohesion and conflict: family influences on adolescent alcohol use in immigrant Latino families. J Ethn Subst Abuse. 2009;8(4):400–12.
34. Castro FG, Stein JA, Bentler PM. Ethnic pride, traditional family values, and acculturation in early cigarette and alcohol use among Latino adolescents. J Prim Prev. 2009;30(3–4):265–92.
35. Corkery E, et al. Effect of a bicultural community health worker on completion of diabetes education in a Hispanic population. Diabetes Care. 1997;20(3):254–7.
36. Warrick LH, et al. Evaluation of a peer health worker prenatal outreach and education program for Hispanic farmworker families. J Community Health. 17(1):13–26.
37. Rhodes SD, Foley KL, Zometa CS, Bloom FR. Lay health advisor interventions among Hispanics/Latinos: a qualitative systematic review. Am J Prev Med. 2007;33(5):418–27.
38. Institute of Medicine. Promoting health: intervention strategies from social and behavioral research. Washington, DC: National Academy Press; 2000.
39. Canino G, Vega WA, Sribney WM, et al. Social relationships, social assimilation, and substance-use disorders among adult Latinos in the U.S. J Drug Issues. 2008;38(1):69–101.
40. Buchanan S. Day labor and occupational health: time to take a closer look. New Solut. 2004;14(3):253–60.