Family Ties and Care for Aged Parents at Home

by

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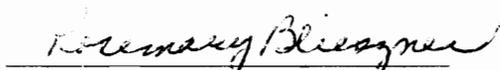
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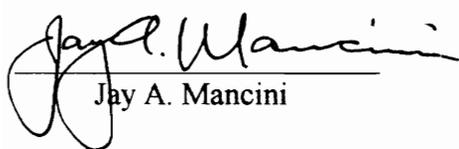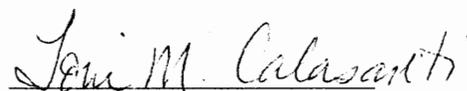
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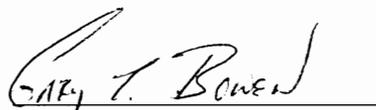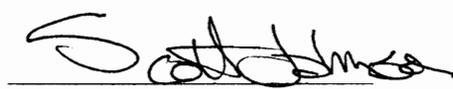
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ABSTRACT

A qualitative study of 15 families caring for an elderly parent in a non-institutional setting was conducted for the purpose of discovering how families perceive and carry out their responsibilities to their older relatives. Forty-three persons representing up to three generations per family were interviewed. They articulated the meaning of their responsibility to care for the parent, how they learned to be responsible to family members, and what experiences inside and outside the family shaped their sense of responsibility. They expressed their views about how family caregiving labor should be divided between male and female members. Questions about the factors that affected use of services provided by persons other than family were asked of all families.

Results suggested that caregiving in this context requires balancing the needs of the parent with those of the whole family. Caregivers learn their responsibilities through incorporating family member expectations, through role modeling of family and friends, and through a continuous process of role-making. A sense of filial responsibility is shaped by feelings and interpersonal ties within the multigenerational family. Although

respondents were divided in their thinking about which gender was best suited to assist the aged parent, most families practiced a very traditional gendered division of labor when helping their parents. Of the factors affecting use of formal care services, need of the older person for additional assistance was the most important. The family's sense of responsibility was not altered by use of formal care services.

Data from this study advance development of family caregiving theory by specifying relationships among perceptions of responsibility to the older person, individual and family ethos, and family caregiving patterns, and by delineating the components of family ethos. Findings affirm previous theoretical work on factors that affect family use of formal services. Results demonstrate that formal care services are valued by elderly persons and their families, and suggest the need for long-term care policies that offer home care services to all disabled adults. Findings indicate that obtaining data from multiple family members is desirable when seeking information about family relationships that contribute to family caregiving patterns.

Finally, I admire, appreciate, and thank my husband, Bill Piercy, and daughter, Andrea Piercy, for their assistance and loyalty to me throughout the past four years. They have been a superb source of support.

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Overview

Providing care to society's older members is an increasingly important task for both families and the social service delivery system. Currently more than 30 million persons aged 65 and older live in the United States (Coward, Horne, & Dwyer, 1992). This age group is projected to double in size by the year 2060, with those age 85 and older increasing from 3 to 18 million during that time period (U.S. Bureau of the Census, 1989). Although many people will enjoy good health well into their later years, many will also need assistance, particularly in their last years of life. Need for care among older adults is primarily a result of declining health and functional ability. Such declines increase in prevalence as persons reach the age group of 85 and over (U.S. Department of Commerce, 1990). Thus, demands upon both families and social services for the care of dependent older persons are projected to increase in future years (Longino, Soldo, & Manton, 1990).

Studies of care provision to older adults clearly demonstrate that families provide the majority of care to their older members with wives, daughters, and daughters-in-law comprising the majority of caregivers (Coward, Cutler, & Mullens, 1990; Stone, Cafferata, & Sangl, 1987; U.S. Department of Commerce, 1990). A recent analysis of caregiving prevalence from the National Survey of Families and Households (Marks, 1996) revealed that approximately 20% of all respondents between the ages of 50 and 64 were caring for an elderly parent. The percentages of men and women in that age group

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who were providing parent care were almost equal (10.9% women, 10.6% men). Marks (1996) also found that 16.4% of all adult caregivers in this study reported giving assistance to more than one person. Taken together, these findings point to the prevalence of parent care in middle adulthood, and to the possibility of caring for more than one relative simultaneously.

Such familial care, as well as care provided by friends, neighbors, or other unpaid sources, is defined as informal care (Travis, 1995). In contrast, the care rendered for pay by individuals or organizations in both the public and private sectors of the economy is defined as formal care (Travis, 1995). Both means of care provision are indispensable to the well-being and quality of life of both older adults and their families. Thus, it is important to understand the relationship between formal and informal care provision; more specifically, to understand the needs and desires of families regarding the optimal division of labor between themselves and formal care providers.

As older persons' abilities to care for themselves decline, they and their families are faced with decisions about how best to manage their lifestyles. Although most families provide help for as long as possible without the use of formal services (Stone et al., 1987), those families for whom caregiving extends over a relatively long period of time do tend to engage formal services (Travis, 1995).

Most research describing the use of formal services has focused upon outcomes, the actual service utilization patterns of older adults and their families. Little research has examined the process by which families develop a system of care provision for their older

members, including whether or not or at what point to involve formal services in their caregiving system. Furthermore, research efforts to identify the factors that influence those decisions have focused primarily upon sociodemographic variables of the older person or primary caregiver, such as age, marital status, or socioeconomic status, or upon the degree of the older person's need for services due to functional limitation. Little research has delved into the ways in which characteristics of <u>family relationships</u> might contribute to the care provided by families. Yet, several researchers have found that adult children who act as primary caregivers to older parents were motivated to do so by affection (Hamon, 1992), love, maternal feelings, and feelings of family ties (Guberman, Maheu, & Maille, 1992). In their measurement of primary caregiver attitudes toward community services, Collins, Stommel, King, and Given (1991) discovered that the caregivers' preferences for providing informal care were the strongest predictors of patterns of utilization of community services. Thus, some of the characteristics of <u>primary</u> caregivers have been captured by prior research, but characteristics of the family unit or extended family as influences upon caregiving patterns have not yet been described.

The purposes of my research project are threefold: first, to uncover and describe important aspects of family relationships that play a key role in influencing family caregiving patterns to dependent older members; second, to improve scholarly understanding of how caregiving roles are learned and gender roles delineated; and third,

to identify the relationship between use of formal services and perceptions of responsibility among families who use such services.

Rationale for the study

If American society is to respond well to the care needs of its older citizens and their families, then an understanding of how families fulfill those needs is paramount for development of family-sensitive public policy, as well as the provision of services that are well-utilized and perceived as effective by those who use them. What seems to be missing from research accounts are the perspectives of the care recipients and their families. Very little is known about how families define their responsibilities to their aged parent, and which types of assistance they desire from formal care providers. A study of family members representing several generations that is designed to explore the process by which caregiving patterns are developed and to determine which aspects of family relationships play important roles in the evolution of the filial caregiving process, has the potential to advance theory and knowledge useful to policy-makers and practitioners.

Research Questions

The following questions were developed after careful review of the empirical literature on family caregiving and service utilization patterns among families caring for dependent older members, including the extensive work of Jaber Gubrium. In The Mosaic of Care: Frail Elderly and Their Families in the Real World, Gubrium (1991) asserted that scholars and professionals know very little about the interpersonal dynamics

and culture of the home and the families conducting caregiving activities in it. He proposed the questions concerning the meaning of caregiving, how caregiving responsibility is learned, and how family ties shape members' sense of responsibility to the older person, as well as their use of services. In addition, questions that explore the gendered division of labor and the effects of service use on perceptions of responsibility to the older person are added to advance knowledge of family caregiving. Hence, the research questions for this study are:

1. What is the meaning of familial responsibility to those concerned with caregiving for older family members?

2. How do families learn what they are, and are not, responsible for in caring for their elderly at home?

3. How embedded is the gendered division of labor in the thinking of family members?

4. How do the customary sentiments and interpersonal ties of the family enter into, and shape, members' sense of responsibility and use of care providers who are outside the family?

5. How does the use of formal caregiving services affect familial or individual interpretations of responsibilities for providing care to the older family member?

Operational Definitions of Key Terms and Concepts

It is important to define several terms for this research project. Because of the exploratory nature of this research, the study participants were active in shaping the definition of family ethos. Therefore, the definition provided here was a working definition, and was revised during the research project.

Activities of daily living. Basic tasks individuals perform daily to ensure their survival. They include eating, bathing, toileting, dressing, and walking.

Caregiver. An individual who assists an elderly person with activities of daily living and/or instrumental activities of daily living, and who often provides emotional support to that person on an ongoing basis.

Caregiving. The provision of physical labor, financial assistance, or emotional support to care recipients (Aldous, 1994).

Caregiving Ethos. The characteristic attitudes and behaviors of an individual or family towards dependencies in oneself or other family members, and beliefs about who should help with those dependencies (Brubaker & Brubaker, 1989). Ethos may be expressed through a person's political or religious orientations, or a general world view. Ethos can also be shaped through prior experiences with formal care services or family caregiving practices.

Dynamics. The complex forces that operate within families to produce communications and behaviors in response to care needs of older members.

Family. One or more persons related to care recipients by blood, marriage, or adoption.

Formal care services. Any care rendered for pay by individuals or organizations in both the public and private sectors of the economy to caregiving families and/or their dependent older members (Travis, 1995).

Informal care services. Any care provided by families, friends, neighbors, or other unpaid sources of assistance (Travis, 1995).

Instrumental activities of daily living. Tasks that individuals perform to maintain healthy, independent lifestyles. They include shopping, home maintenance and repair, cooking, housecleaning, and maintaining finances.

Occasional Caregiver. A person who provides occasional, episodic assistance in the care of an elderly family member. This person may back up primary and secondary caregivers in their absence.

Personal autonomy. An individual's ability to "make and execute deliberated decisions to satisfy needs and attain goals in a manner consistent with one's values" (Cicirelli, 1992, p. 14).

Primary caregivers. Persons who assume the majority of the responsibility for providing care to a dependent older person. They usually provides care on a routine basis, incorporating it into their lifestyles. Coordination of the care provided by others may be part of their caregiving functions.

Secondary caregivers. Persons who assist the primary caregivers in providing care to a dependent older person. They may serve as backup to the primary caregiver, or be assigned a specific task to complete on a regular basis.

Service utilization. The use of formal care services by dependent older persons and their families.

Values. "Psycho-normative concepts...used to inform us about psychological traits or states of people, and to indicate normative stances of the person--how he or she appraises or evaluates the world" (Arcus & Daniels, 1993, p. 80).

<center>Summary</center>

The purposes of this study are to advance knowledge of family caregiving by describing the ways in which family relationships contribute to care provision for older members, depicting how caregiving roles are learned and sense of responsibility is shaped among family members, and identify whether and how use of formal services alters family members' feelings of responsibility to the older person receiving care. The questions posed for study have been identified. The next chapter reviews pertinent literature in the family caregiving and service utilization fields of study, and describes the theoretical frameworks used to guide interpretation of the study's findings.

Chapter II: Review of the Literature

Overview

This chapter begins with a discussion of the symbolic interactionist and socialist feminist frameworks upon which this study is based. That is followed by a description of theoretical perspectives on family caregiving. The third section of this chapter reviews pertinent prior research in family caregiving. It is followed by a presentation of empirical support for the construct of family ethos. The fifth section offers a critique of the methods used in earlier studies in relation to the focal concerns of this research project. The final section of this chapter discusses how this study extends knowledge in the field of family caregiving.

Theoretical Frameworks

The theoretical framework of symbolic interactionism may be used to understand family responses to a member's need for assistance. LaRossa and Reitzes (1993) described symbolic interactionism as a framework for understanding how humans create symbolic worlds and how these worlds shape their behavior. Symbolic interactionists Mead and Blumer stressed the development of meanings as a basis for personal behavior. They posited that important meanings develop during the course of interpersonal interaction, and are modified through an interpretive process used by persons as a way of responding to what they encounter in society (LaRossa & Reitzes, 1993). According to these principles, each family member's behavioral response to a member's need for help is guided by definition of the nature and extent of personal responsibility to the family; a

meaning developed and modified over years of interaction with members of that family. Feelings of responsibility held by family members may be shaped, in part, by family rules or traditions developed in interpersonal interaction which become an ongoing part of family history.

Implications of this framework are that familial responses to members' needs are varied, depending at least partially upon subjective interpretations of responsibility for care made by each family. Such diversity in interpretations of responsibility has been documented by Gubrium (1988). He used the approaches of phenomenology and ethnomethodology in studying family caregiving, with a focus upon the interpretations of responsibility for providing care that are embedded in family discourse. In their explanation of family discourse, Gubrium and Holstein (1993) stated that "the study of family discourse highlights how language serves to assign meaning to objects and social conditions" (p. 655). They asserted that discourses "are not simply words spoken or written about an aspect of reality; they are simultaneously constitutive of reality" (p. 661). In order to understand familial responses to member needs for care, it becomes necessary to comprehend their realities as they have interpreted them. Grasping familial reality may be accomplished by an analysis of their discourse about such issues as who is responsible for providing care, what kinds of family rules and traditions exist about caregiving behaviors, and what, if any, limits exist to familial responsibility for rendering care to a needy member.

According to symbolic interactionists, familial interpretations of who is responsible for providing care are likely to reflect the influence of larger cultural and societal processes. In American society, caregiving to needy elderly is provided mostly by women (Stone, Cafferata, & Sangl, 1987). To help explain this phenomenon, Finley (1989) tested four existing hypotheses of family labor on a sample of caregiving women. The time-available hypothesis posits that a person's time available for family labor is a result of the competing demands of other roles that person must fulfill. The socialization/ideology hypothesis suggests that the division of family labor is influenced by gender-role attitudes acquired during the process of socialization. The external-resources hypothesis posits that the person with the most resources in a family, such as education and income, will hold the most power in that family, and make the decisions regarding division of labor. The fourth hypothesis, specialization-of-tasks, predicts that men specialize in work roles outside the home, and women specialize in work tasks within the home, including caregiving and housework chores (Finley, 1989). Finley found that none of the four hypotheses explained the predominance of women as caregivers to the elderly. She suggested that the structural nature of gender differences might provide some clues to the reasons why women provide the majority of care to elderly family members. The structural nature of gender differences encompasses the notion proposed by England and Farkas (1986) that the assignment of household labor to women has been institutionalized to the point that it appears unresponsive to household variations in male power or ideology. Finley (1989) extended this analysis to caregiving

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labor, stating that "a lack of contributions of males to family caregiving is not seriously challenged in a society that expects little of the 'emotional work' (England & Farkas, 1986) to come from males. Males may feel that they are contributing" (p. 85). In addition to Finley's ideas, socialist feminist theories have recently been offered to explain the phenomenon of the gendered nature of caregiving.

According to socialist feminist theory, the current division of labor in U.S. society can be traced to systems of capitalism and patriarchy. The socialist feminist perspective encompasses Acker's (1989) view of gender as "structural, relational, and symbolic differentiations between women and men" (p. 238). Calasanti and Bailey noted that "this perspective posits that men historically have controlled women's home labor through a gendered division of labor. Under capitalism, patriarchy expanded from the private sphere into the public" (1991, p. 39). As a result, in today's society, men dominate women in both spheres. Thus, even though more women than ever have joined men in the paid labor force during the second half of this century, with some holding professional positions of a stature equal to those of men, most women have added a second shift responsibility for doing family labor (Hochschild, 1989). These responsibilities include providing most of the hands-on care to elderly family members.

Research has documented that employed adult daughters are heavily involved in the care of their elderly mothers (Brody & Schoonover, 1986). Stoller (1993) reported that most lay or unpaid care and consultation to older persons was provided by women. Analyzing her results from a socialist feminist perspective, she stated that:

women's responsibility for unpaid caregiving both maintains and reproduces

current economic relations and is reinforced by patterns of occupational

segregation and wage discrimination in the labor force, which in turn support the

belief that women encounter fewer opportunity costs than men in assuming

caregiving responsibilities. (p. 159)

When this situation is coupled with a cultural ideology that views women as endowed

with a 'natural affinity' for caregiving and holds that women's place is in the home, it

becomes clearer why women provide the majority of care to older family members,

regardless of personal economic difficulties or stressful family circumstances.

It appears that women's assumption of caregiving responsibilities has become so

institutionalized that many women feel that they do not have a choice about whether or

not to provide care to elderly family members. Aronson (1992) noted that "prevailing

ideologies provide images, vocabularies, and symbols that powerfully shape our thinking

about ourselves and our social worlds, defining our conceptions of what is right or

desirable and what is possible or thinkable" (p. 12). In her study of caregiving daughters,

she found that most had incorporated normative expectations of the roles played by men

and women in families. Her respondents excused their spouses and male siblings from

caregiving responsibilities, and felt guilty when they set limits on what they would do for

their mothers. They truly viewed caregiving to older parents as their exclusive

responsibility. Thus, the statements of Aronson's (1992) respondents lend credibility to

Finley's (1989) conclusion that the gender difference in caregiving to elderly family

members has become institutionalized just as housework is institutionalized as women's work.

Recent developments in socialist feminist theorizing have linked gender as a structural property of social organization and culture as an organizer of social identity (Wharton, 1991). Wharton argued for an examination of "processes through which both social organization and identities become gendered and are reproduced as such over time" (1991, p. 384). Research conducted utilizing this framework would incorporate the influences of both the interpersonal relationships among families and the formal organizations and institutions of the larger society. The present study addresses the micro or interpersonal level of society through an analysis of family discourse regarding caregiving to dependent elderly family members. In contrast, a study focused upon the macro level of society would examine the role that institutions, such as educational and governmental, play in fostering and reproducing gendered identities.

<u>Theoretical Perspectives on Family Caregiving</u>

Relatively few attempts have been made to develop a comprehensive theory of family caregiving. Several researchers who have explored family caregiving behaviors have adapted the Andersen behavioral model of health services utilization (Andersen, 1968; Andersen & Newman, 1973). According to this model, the use of health services by individuals and families is an outcome predicted by a combination of predisposing, enabling, and illness factors. Predisposing factors include demographic variables such as age, gender, and marital status; social structure variables such as race, occupation, and

religion; and belief variables such as attitudes towards health services and knowledge about disease. Enabling factors are divided into family and community variables. Family variables include income and health insurance; community variables include availability of health care personnel and facilities in the community, as well as its urban or rural character and price of health care services. Illness factors include both perceived and evaluated illness variables such as diagnosis, symptoms, and disability. These illness factors signal a need for formal services. Two research teams have produced expansions of the Andersen model based upon empirical research.

Bass and Noelker (1987) examined these three factors (predisposing, enabling, and need characteristics) as they applied to both the primary caregiver and the care recipient, and found that caregiver need characteristics played a significant role in decisions about whether or not to use formal in-home services for the elderly care recipient. Thus, they argued that inclusion of both caregiver and care recipient in the Andersen conceptual framework was necessary to understand and predict use of health care services by elderly persons and their families. They also called for more research into "how family-related factors influence service use" (Bass & Noelker, 1987, p. 193).

Recent work by Montgomery and Kosloski (1992) based upon the Andersen model affirmed the family as the proper unit of analysis for investigations of health services use by older persons and their caregivers. In their view, decisions to use formal services are a function of family background characteristics (predisposing factors); needs of the family (defined as both care recipient and primary caregiver) such as primary

stressors (care recipient's level of impairment and amount of care required) and secondary stressors (caregiver health, level of burden and depression); and nature of the service and its delivery (enabling factors). Montgomery and Kosloski also included perceived utility of the service to the family as a mediating variable in the family's decision-making process. Among important predisposing characteristics in their model are both the normative expectations of the family for care provision and the personal expectations of the caregiver and/or elder for service use.

The first empirical test of their model determined that an interaction between the nature of the caregiving relationship (whether caregiver was a spouse or adult child) and perceived need for services predicted use of four discretionary health care services by older persons and their families (Kosloski & Montgomery, 1994). In order to understand service use patterns by families with dependent older members, they concluded, it is critical to examine who was involved in defining the need for service within those families. Montgomery and Kosloski thus retained selected familial characteristics in their conceptual model of service utilization patterns among dependent elderly and their families. Additional work on aspects of ethnicity and cultural values that may contribute to differential service utilization patterns among families is ongoing (Montgomery, personal conversation, Sept. 12, 1994).

The recognition of the family's definition of need for services as a crucial variable in the service utilization patterns of older persons and their families was an important step towards the development of a theory of family caregiving. However, it is likely that other

aspects of family relationships play a role in what kinds of caregiving decisions are made.

One attempt to delineate the role that family characteristics play in the service utilization

patterns of older adults receiving care is the family caregiving theory of Brubaker and

Brubaker (1989). This theory depicts caregiving outcomes (type of services used) as a

function of the type of dependency manifested by the older adult, the perceptions of

responsibility to provide assistance on the part of the family, and the individual and

family ethos. Individual and family ethos is hypothesized to mediate both perceptions of

responsibility to provide assistance and the actual type of services used by the family.

Although perceptions of responsibility to provide assistance to older family members has

received some attention in prior research on caregiver service attitudes (Collins et al.,

1991), the concepts of individual and family ethos have been neither explored nor

explicated in prior research on family caregiving decisions. An understanding of the role

that individual and family ethos plays in determining family caregiving behaviors has the

potential to increase knowledge of which family characteristics are important to include

in models of service utilization, and it might also advance current efforts to develop a

comprehensive theory of family caregiving.

<div align="center">Critical Analysis of the Research: Family Caregiving Patterns</div>

Family caregiving research has proliferated in recent years. Most of the studies are

characterized by cross sectional design and use of quantitative methods (Kahana, Biegel,

& Wykle, 1994). This research has identified several trends in caregiving to dependent

older persons. Some of these trends, such as female family members comprising the

majority of primary caregivers and families opting for informal care as long as it remains possible were reviewed in the introduction; additional trends are discussed in the following paragraphs.

Older persons usually need assistance from others when they develop one or more functional impairments, customarily defined as difficulty in performing basic activities of daily living (ADLs), or instrumental activities of daily living (IADLs). Some older people express a need or desire for help from others; in other cases, the initiation of caregiving may occur when a family member notices a problem and offers help. Using data from a large national sample ($\underline{N}$= 42,000), Coward and his associates (1990) found that increasing levels of elder impairment led to changes in the source(s) of assistance. Most older persons in their study had no help or relied primarily upon informal sources of help (family or friends) until their levels of impairment were quite substantial (difficulty performing 9 or more tasks defined as ADLs or IADLs). At that point, the formal service system was usually involved, though less frequently among the rural elders who were surveyed. This self-reliance or reliance exclusively upon informal sources of care may reflect a high priority placed upon personal autonomy by many older persons and their families in America.

Substantial evidence suggests that both older adults and their families make every effort to preserve the autonomy of the older person for as long as possible. High (1988) reported that older persons perceived their individual autonomy as extendible during health crises by using family members as surrogate decision-makers. In his study of

autonomous and paternalistic decision-making among mother-daughter dyads, Cicirelli (1992) found a stronger belief in parental autonomy among the care-providing daughters than among the care recipient mothers. The adult children in Matthews and Rosner's (1988) study chose to provide the minimum amount of care needed by their parents, even as parental need increased. Thus, the desire of older adults and their children to preserve parental autonomy for as long as possible, coupled with necessity to do so in some families because of other responsibilities or limited financial resources, may help explain the trend of reliance primarily upon informal caregivers, particularly family, for dependent older persons. This desire for preservation of autonomy may be part of an individual and/or family ethos. Additional factors also help explain the reliance upon informal sources of care.

Frequently, the relatives of the dependent older person perceive themselves as best suited to the job of providing assistance because of their unique or special knowledge of the older person's preferences and needs (Hasselkus, 1988; Sussman, 1977). In a first test of their Community Service Attitude Inventory, Collins and associates (1991) determined that scores on the preference for informal care subscale of the measure were the strongest predictors of use of community services among the five subscales in the survey. The other subscales included concern for opinions of others, confidence in the service system, belief in caregiver independence, and acceptance of government services. Lower use of formal services was associated with stronger preferences for informal care among caregivers surveyed. However, their sample of 180 caregivers was composed of

two-thirds spouse caregivers, a group that customarily tolerates higher levels of care recipient disability without turning to formal service use than do other caregivers (Horowitz, 1985). A sample consisting of other types of family caregivers such as adult children might produce different results.

Caregiving Patterns of Adult Children

The involvement of adult children in parent care has received limited attention from gerontologists and family scholars. Three studies that describe important aspects of sibling behavior in caregiving families are reviewed here for their contributions to the understanding of family caregiving when adult children are primary caregivers.

Matthews and Rosner (1988) interviewed 50 pairs of sisters to ascertain the extent of caregiving provided by each sibling, how decisions regarding the distribution of labor were made, how (if at all) relationships with siblings had changed since parent caregiving commenced, and how satisfied primary caregivers were with the current caregiving arrangements. Several important findings emerged from the qualitative analysis of these data. First, when parental need became apparent, the siblings developed a system of caregiving that included attempts to make decisions regarding parental care "in concert" (p. 187) with one another, made more frequent contact with each other to discuss and coordinate tasks, and adhered to the unspoken principle of least involvement necessary in parent care to preserve parental independence. Second, the respondents described five styles of participation by themselves and their siblings. Routine assistance was provided by adult children who became primary caregivers; care tasks became part of their ongoing

activities. A backup style was exhibited by those siblings whose assistance was not routine but reliable when requested by the primary caregiver. A circumscribed style of assistance described siblings whose task performance was limited but predictable, such as siblings who made a weekly telephone call to dependent parents. Some adult children exhibited a sporadic style of participation in parent care. These siblings provided help "at their own convenience" (p. 189). Lastly, some siblings were described as dissociated from the parent caregiving system. These family members did not participate in decision-making or caregiving provisions made by their siblings.

It is noteworthy that the adoption of one of these styles was gender-related. Routine and backup styles were more likely to be embraced by sisters than brothers. Brothers were more likely to be described as circumscribed, sporadic, or dissociated in their styles of parent caregiving. However, only women were interviewed for this study; thus, the composition of families in this study included at least two female adult children, in addition to sons. Generalization of this result to the general population is somewhat limited by its exclusion of male voices.

However, Matthews (1995) also studied adult children's caregiving patterns when the family was composed of one sister and one or more brothers. In this study, 50 brother-sister pairs were interviewed. The sisters in these families performed or were given credit for doing the bulk of the parental caregiving. Three factors explained this result: first, cultural assumptions about gender-appropriate behavior were adopted by the families, so that families deemed the sister as the best provider of care; second, sisters

were considered "in charge" of care provision; and third, both brothers and sisters downplayed the contributions of brothers to parental care.

Taken together, these studies provide important information about patterns of sibling assistance among family members whose parents need care. They provide a clear picture of parental caregiving spearheaded by daughters, reveal some of the reasons for the existence of this pattern, but also illustrate the contributions of sons. The next study further illustrates patterns of sibling assistance.

Cicirelli (1992) interviewed 62 parent-adult child dyads about many aspects of family caregiving. Although he focused primarily upon autonomous or paternalistic decision-making patterns in his respondents, he did ask the adult children who were primary caregivers about the process of decision-making in their families, plus how their sibling's assistance was incorporated into parent care. Decisions about what should be done to help parents and who should do it were discussed by all siblings either in meetings or by phone in almost half of the study's families (43%); in another 18% of families, all planning and implementation of care was performed by one or two siblings. An additional 34% of respondents' families were characterized by primary caregiving adult children who called upon siblings for help or assigned tasks to them. Only 2% of all respondent families had no specific plan or haphazard provision of care by siblings other than the primary caregiver. Although limited in generalization by its small sample size, this study offers documentation of multiple adult child involvement in decision-making and care provision to dependent parents.

Cicirelli (1992) explored the issue of incorporating sibling assistance by asking two questions: Did all children work together or independently to provide help to the parent? How well could the primary caregiving siblings work with their brothers and sisters to provide this care? Again, almost half of the respondents (47%) stated that all siblings worked together to provide assistance to parents. By contrast, 27% of the study participants said that each sibling acted independently. The remaining respondents described several patterns of working relationships, with 13% saying that none of their siblings helped with parent care. To the question of how well siblings could work with one another, the majority responded very well (57%). Only 14% said that working together was impossible or would be unproductive. The responses to these questions suggest that the majority of sibling groups are characterized by some degree of willingness to cooperate with each other in provision of care to aging parents. Perhaps these results can be explained, at least in part, by the existence of a family ethos regarding care for dependent older members.

Only a few investigators have explored perceptions of responsibility for family care among multiple generations of adults. One project concerning this topic was Rossi and Rossi's large study of parent-child relations across the life course.

With the statement that "an understanding of the role of norms in affecting concrete kin relationships requires understanding how general rules are interpreted in specific settings with specific kinpersons" (p. 198), Rossi (1993) described the measurement strategy used in the Rossi and Rossi (1990) study of intergenerational

relationships. Each respondent in the study received a set of 32 brief vignettes randomly drawn from 1600 possible vignettes. All vignettes depicted a family member in some sort of difficulty, with type of family member in trouble (parent, aunt, sister, etc.) varied in each vignette. The respondent rated the degree of obligation felt in each situation. Several findings provided interesting insight into the factors that affect the strength of feelings of obligation to assist family members.

Among the chief findings was the symmetry of normative structure; that is, the degree of relatedness between respondent and kinperson in the vignette predicted the degree of obligation felt by the respondent (Rossi, 1993). Degree of relatedness was defined as the number of connecting links that existed between the respondent and kinperson. Felt obligation was greatest towards primary kin: one's parents and children; followed by secondary kin (grandparents, siblings), tertiary kin (uncles, nieces), cousins, and lastly, nonkin (friends, neighbors, ex-spouses).

Other findings highlighted the importance of gender in understanding strength of normative obligation. Greater feelings of obligation were invoked by female kin in difficulty than by male kin, with the exception of parent-child relationships. Female respondents expressed greater feelings of obligation to secondary and tertiary kin than did their male counterparts. Gender combined with personality traits to predict levels of obligation: highly expressive men indicated greater levels of obligation than men who were low in expressivity, but women's levels of obligation were equal to those of highly expressive men.

Family characteristics also predicted varying levels of obligation. Levels of affection, accessibility, and early family experiences were foremost among the significant family characteristics. High levels of parental affection and accessibility in families predicted higher feelings of obligations to kin. Families who had experienced problems with an emotional basis, such as alcoholism or physical violence, expressed lower levels of obligation to kin and higher levels of obligation to nonkin (Rossi & Rossi, 1991). By contrast, respondents in families who had experienced adversity such as a death in the immediate family or the rebelliousness of children demonstrated higher levels of kin obligations than respondents whose families had not experienced such adversity. Although not surveyed in this study as a form of adversity, perhaps persons whose families were required to respond to the long-term care needs of their members during their childhood would experience higher levels of felt obligation towards kin than those of individuals whose families did not face this situation. These results highlight the contribution of familial characteristics and early family experiences to the strength of perceived responsibility to family members in need.

Taken as a whole, these findings suggest that feelings of normative obligation vary widely according to personality type, gender, and family characteristics of the respondent. Degree of relatedness and gender of the persons needing and providing assistance also play an important role in variations of such feelings. Building on these results, one of the purposes of my study was to explore how feelings of responsibility of adult children and grandchildren translate into actual caregiving behaviors in their

families, including use of informal and formal services. The next section reviews previous research on the use of formal care services by families caring for their older members.

<u>Utilization of Formal Services by Caregiving Families</u>

Several investigators have explored the use of various formal care services by older persons and their families, including in-home care (Bass & Noelker, 1987; McAuley & Arling, 1984) and respite care services (Caserata, Lund, Wright, & Redburn, 1987; Lawton, Brody, Saperstein, & Grimes, 1989; Montgomery & Borgatta, 1989). Their studies have documented some of the factors affecting the varying levels of service use, such as age of the care recipient, severity of the care recipient's illness or functional limitation, and caregiver stress levels. However, none of these studies incorporated measures of characteristics related to family members' sense of responsibility for providing services. In the discussion of their study results, several researchers have suggested that there is a need to determine the importance of familial characteristics in explaining service utilization patterns among elderly persons and their families. The work of these researchers is discussed below.

Lawton, Brody, Saperstein, and Grimes (1989) studied use of various types of respite care services for family caregivers. They found that 58% of those offered such services actually used them, and that in-home respite care was the most popular type of care provided. Concerned about caregivers who failed to use these services, Lawton and his colleagues (1989) suggested that researchers should study <u>in depth</u> various caregiver

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attitudes toward such issues as "having a stranger in the home, relinquishing the oversight of a relative to a stranger, giving oneself pleasure, and other psychological orientations toward caregiving" (p. 28). These researchers seem to touch upon concepts of caregiver/family perceptions of responsibility and family ethos in decisions made regarding use of respite care services.

Caserata, Lund, Wright, and Redburn (1987) also studied the utilization of community services by caregivers to dementia patients. They determined that lack of need for such services, reluctance to leave the family member with a stranger, excessive behavioral and emotional problems, and expense were reasons given for failure to use community services. An especially interesting finding of this study was that caregivers who used formal services were similar in many ways to those not yet ready to use services and those who were unwilling to use formal services. They recommended research that would help identify other factors that predict service utilization, factors that "have not normally been considered in service utilization research" (Caserata et al., 1987, p. 213). This research team also recommended use of qualitative methods to uncover such factors.

Collins and colleagues (1991) investigated the relationship between caregiver attitudes towards formal services and their use of community services such as respite care and adult day care. Concerned about the low rates of service use among caregivers with significant burden, they identified caregiver attitudes that predicted patterns of service utilization. They developed and tested the Community Service Attitude Inventory, a

questionnaire that identified five caregiver attitudes potentially predictive of formal service use. The attitude with the greatest predictive power in their study was Preference for Informal Care, with Belief in Caregiver Independence "a modest predictor of the frequency of current service use" (Collins et al., 1991, p. 759). These results suggested that perceptions of responsibility to provide care among family caregivers might be more important than perceptions of the services themselves, and hinted at the potential importance of both individual and family ethos in making decisions about who will provide care to older members.

MaloneBeach, Zarit, and Spore (1992) studied the use of case management and community-based long term care services for Alzheimer's patients and their caregivers, with the purpose of determining the barriers to utilization of such services. They found that prior experiences with agencies that provided such services had an impact upon their use and satisfaction with use. Concerns over the quality of care, caregiver lack of control over scheduling, and inflexible agency policy were cited as reasons for caregiver frustration and attrition from the formal service system. Another finding of MaloneBeach and associates was that "caregivers...had more difficulty accepting assistance if the focus was on their needs or if the service was perceived as merely babysitting..." (p. 154). Results of this study suggest the need to examine perceptions of responsibility for providing assistance, individual and family ethos, and the manner in which services are perceived and/or experienced by caregiving families in order to improve understanding of familial use of formal services.

It is evident that those who have studied formal service utilization patterns among older adults and their families recognize that research has yet to explain adequately the role played by family attitudes and behaviors in family caregiving behaviors, including service use. Thus, my study focused upon aspects of family relationships that contributed to decisions about whether or not to use formal care services.

<u>Empirical Support for the Family Ethos Construct</u>

This review of family caregiving research highlights several factors that guide decisions made about caregiving provisions: (a) that the older person's autonomy be preserved as long as possible, (b) that needed care be provided by informal sources (family, friends, and neighbors) whenever possible, (c) that women in the family are most likely to assume the primary responsibility for informal caregiving to an older parent, (d) that several siblings are often involved in aspects of parent care, and (e) that caregiver attitudes toward formal care services influence the use of these services. From these empirical findings, it is reasonable to conclude that many, if not most families, define caregiving to their older members as primarily <u>their</u> responsibility, not the responsibility of others.

Brubaker and Brubaker's (1989) theory of family caregiving posits that perceptions of responsibility for providing services to dependent older persons and use of various types of services is mediated by individual and family ethos. Such ethos is likely to be a dynamic construction of the family through its interactive processes. The theory of symbolic interactionism focuses upon interactive processes that lead to the creation

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and refinement of meanings important to both individuals and families. According to this theory, family members will then act towards a need for parent care on the basis of the meanings that providing such care have for them.

The empirical findings of Rossi and Rossi (1990) offered substantial evidence for feelings of strong obligation to parents in situations in which they were in need of assistance. In symbolic interactionist thinking, strong feelings of normative obligation arise because of the meanings attributed to such situations. Thomas and Thomas's concept of definition of the situation suggests that "human action cannot be understood apart from the subjective interpretations given to the situations" (La Rossa & Reitzes, 1993, p. 140). It is my belief that parents' needs for care invoke a strong sense of responsibility among their adult children to take action, and that how they decide to provide care, and what resources they use (formal and/or informal), result at least in part from the individual and family ethos regarding how to respond to dependencies in the family. A family's ethos leads its members to define the situation, then act upon that definition.

Although it is difficult to define a construct as abstract and intangible as family ethos, evidence of such a phenomenon exists. In his 17-year study of family processes, Reiss (1981) identified shared experiences of family life; experiences that played "a significant role in shaping the family's perception of and transaction with its external world" (p. 2). Reiss described these experiences as assumptions, constructs, fantasies, and expectations about the social world. Much of his findings were obtained through

observation of family interaction in laboratory settings, a method which permitted the documentation of the family's construction of shared meanings as they unfolded. The present study was designed to document shared meanings by observing and interviewing, whenever possible, multiple family members in interaction with one another. Individual family members who played important roles in the formulation of such meanings were also interviewed, and gave corroboration of the shared meanings of parental caregiving.

<div align="center">Critical Analysis of the Research: Methods</div>

As previously noted, the majority of studies of family caregiving, including use of formal and informal services, are characterized by use of quantitative methods to explore constructs and phenomena of interest (Kahana, Biegel, & Wykle, 1994). Survey methods with large national or regional samples were used in several of the studies reviewed here (Caserata, Lund, Wright, & Redburn, 1987; Coward, Cutler, & Mullens, 1990; Stone, Cafferata & Sangl, 1987). The findings of these studies produced much useful information on the profiles of caregivers and care recipients and utilization patterns of formal care services for dependent older persons. However, these studies omitted important areas that contribute to the understanding of intergenerational relationships and utilization of formal care services for the population of interest.

Recent research designed to develop models of formal care services utilization (Bass & Noelker, 1987; Kosloski & Montgomery, 1994; Montgomery & Kosloski, 1992) have advanced the understanding of various factors important to service utilization among the dependent elderly and their families. However, these models, all based upon

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the Andersen and Newman (1973) framework, have explained only 15% to 20% of the variance in service utilization patterns. In particular, the predisposing variables have performed quite poorly in multivariate analyses. Kosloski and Montgomery noted that some of these variables, such as "race, age, and relationship between caregiver and elder...clearly serve as proxies for more fundamental processes" (1994, p. 34). They urged a focus upon differing belief and value systems among caregiving families in future research projects in an effort to develop further the role of predisposing variables.

Another gap in knowledge about use of informal services stems from the lack of data from all family members or other informal sources of assistance involved in caregiving to older persons. In most studies, family member involvement is inferred from measures of family structure (Townsend, 1993) or the reports of primary caregivers (Cicirelli, 1992). In only two studies (Matthews, 1995; Matthews & Rosner, 1988) is such information corroborated by another family member. It is evident that studies of multiple family members are needed to gather more complete data on the nature of multiple family member involvement in caregiving to older members.

A few studies reviewed here used the qualitative method of intensive interviewing to learn more about patterns of caregiving among siblings (Cicirelli, 1992; Matthews & Rosner, 1988), and motivations for caregiving (Guberman, Maheu, & Maille, 1992). However, I was unable to locate any studies that sampled three generations of family members. Townsend (1993) noted the greater likelihood of researcher specification of individual characteristics of care recipients and caregivers as variables predicting service

use than specification of interpersonal or systemic variables. However, the relationships among multiple generations of family members are likely to contribute in some important ways to the use of formal care services for dependent older persons. Because the conceptualization and measurement of family level variables is a difficult task (Marcos & Draper, 1990), qualitative research designed to contribute to the formation of family-level constructs such as family ethos is an important first step in that process.

How the Study Extends Knowledge of Family Caregiving

A study of family relationships with a specific focus on the role that both individual and family ethos play in caregiving behaviors could further development of family caregiving theory. It could also assist researchers in determining when families are most likely to perceive formal services as most beneficial to them.

This study could contribute to increased understanding of both the processes and outcomes of family caregiving to dependent older parents in several ways. First, through an exploration of how families learned and developed a sense of filial responsibility, I can identify the salient components of an individual and family ethos and their roles in family caregiving to aged parents. Identification of these components may help in developing measures of family ethos.

Second, identification of how family ethos might be associated with the use or nonuse of formal care services is crucial. Although the limited sample size precludes generalization to all parent-caregiving families, a thick description (Gilgun, 1992) of the families' ethos development and decision-making processes might reveal important

themes that differentiate families who do not involve formal care services from those families who do opt for use of such services. The outcomes of this approach should contribute to the development of a family-level variable that can be included in current or future models of service utilization by caregiving families.

Third, this study is among the first to elicit the views of multiple family members involved in caregiving regarding processes of development of a sense of responsibility for providing care and development of family ethos. By interviewing several family members, I capture elements of family process that "can be understood only by knowing both the shared commitment of the family and the idiosyncrasies of individual members" (Marcos & Draper, 1990, p. 15). The findings of this study contribute to scholarly understanding of family caregiving as a dynamic process of task performance and decision-making.

Chapter III: Methods

Overview of the Research Design

The research design for this project was exploratory, therefore, qualitative

methods of data collection and analysis were used. Many scholars have recommended

qualitative methods of research for the understanding of meaning-making, interpretive,

and decision-making processes engaged in by individuals and families (Daly, 1992; Miles

& Huberman, 1994; Sankar & Gubrium, 1994). Sankar and Gubrium argued eloquently

for the use of qualitative methods in gerontological research with a focus on process:

> Qualitative research has special uses. In situations in which variables are
>
> unknown,...where the focus is on the dynamics of a situation...where the very
>
> meaning or definition of the issues under study is unknown or not agreed upon,
>
> then qualitative research can bring clarity and understanding through its attention
>
> to meaning, process and context (1994, Introduction, p. x).

Rosenblatt and Fischer (1993) also described qualitative methods of family

research as most appropriate for use when the goal of the research is to uncover

perceptions and meanings about family roles. They wrote that qualitative methods are a

strong means for theory testing and revision. One goal of this research project is to

develop the construct of individual and family ethos regarding family member

dependencies by exploring how members of the multigenerational family form and enact

their caregiving roles. Another goal is to determine how their role enactment affects and

is affected by the use of formal care services.

The strategy of inquiry used in this project was collective case studies as described by Stake (1994). The primary method of data collection consisted of intensive interviewing of families individually or in groups. Data analysis followed the procedures and techniques suggested by Bogdan and Biklen (1992) and McCracken (1988), facilitated by use of the computer software program entitled Qualitative Data Analysis Software for Research Professionals (QSR NUD*IST)™ (Richards & Richards, 1995). Data collection and analysis procedures are described in detail in subsequent sections of this chapter.

<u>Sample</u>

<u>Description</u>. A sample of 15 families who were providing care to an elderly family member residing in a non-institutional setting participated in this study. These families provided a wealth of information with which to compile a comprehensive description of family caregiving responsibilities and offered explanations of development of a sense of responsibility for providing assistance and use of services.

Use of services to assist older members and their families ranged from no use of formal services to use of several formal care services. It was difficult to locate families who were not using some formal services, even when the need for assistance was minimal. However, the majority of the older persons receiving help in this study required assistance with one or more activities of daily living; these types of activities frequently necessitated the use of outside help. Additional aspects of the sample selection process are described later in this chapter.

The population from which the sample came was residents of a middle-sized metropolitan area (population = 380,000) in a Southeastern state that is home to the investigator. Because of the small sample size and methods of recruitment, the composition of the sample was Caucasian and predominantly middle-class. The sample represents the majority of the population in the study area.

Selection. Sample selection was nonrandom and employed strategies of multiple-case and purposive sampling (Miles & Huberman, 1994). Multiple case sampling, with its focus upon sampling similar and dissimilar cases, contributed to the development of a rich theoretical formulation of family caregiving practices. Purposive sampling allowed a choice of participants with varying characteristics that enhanced opportunities to develop theory.

Participants for the study were obtained in several ways. Local ministers representing several denominations were contacted to facilitate access to families that were providing care to an elderly parent. Personal acquaintance with several ministers in the study's setting enhanced opportunities to sample from their (and others') congregations. To insure that some of the sample families were using formal care services, several agencies in the community were contacted. Agencies that made referrals included the Life Abilities Program (formerly Easter Seal Society), Senior Action Center, and St. Francis Hospital Home Health Care. In addition, several personal acquaintances made referrals. Full oral and written explanations of the research project were provided to referral sources during meetings with them.

Cooperating referral sources identified families from their congregations or programs with elderly parents who required some level of assistance with daily activities in order to remain at home. They then provided me a list of families who consented to be contacted. During the initial telephone contact, I gave interested family members an explanation of the study and discussed eligibility criteria with them. If at least two family members expressed interest in participating in the study, I conducted an eligibility assessment of the family. The assessment process will be described after a discussion of sample recruitment problems.

Sample recruitment problems. In the original design of this research project, families were to be drawn from the middle class, a family group interview was proposed for each family in addition to individual interviews with the primary caregiver and other family members, and the care recipient was a required participant. To recruit a sample with those characteristics, I met with 14 potential referral sources representing community agencies, support groups, and ministers during a 6-week period in 1995. By the end of that period, I had received just one referral. I then spoke with several referral sources to determine what difficulties they had in helping me recruit families for the study. They outlined four problems in recruitment. First, the eligibility criteria, specifically social class status and adult children as primary caregivers, eliminated a substantial portion of the clients they served. Second, the primary caregiver felt too burdened to take on the additional responsibility of giving one or more interviews. Third, many older persons were unable to be interviewed because they had experienced short-

term memory problems. Fourth, caregivers felt that group interviews were not viable options for their families, because of unwillingness of family members to participate, or concerns that such interviews might create or exacerbate problems among family members who did participate.

These problems led me to consult with researchers and practitioners about revised procedures. As a result, the eligibility criteria were altered in several ways. First, a family of any social class status could participate in the study. Second, the required group interview was deleted in favor of individual interviews with at least two members of each family. Third, the care recipient's participation in interviews became optional.

The new participation criteria quickly led to recruitment of 15 families for the study. With the inclusion of families from all socioeconomic strata, the study findings illustrated two important issues: the importance of financial resources in the patterns of utilization of formal care services, and the similarity of relationship issues in caregiving families of widely disparate economic means. In addition, the use of individual interviews yielded important information about family relationships that was unlikely to be revealed in a group interview. Had such information been discussed openly, the risk of negative reactions among family members post-interview might have increased substantially. Much of this information dealt with conflicted or strained family relations, and was validated in additional interviews with other members of those families. Thus, the revised research design still captured the essence of family relationships in caregiving

families, and contributed some information about similarities and differences in families of varying socioeconomic status.

Eligibility assessment. Level of impairment was assessed by use of part of the screening instrument for nursing home placement developed by the Community Long Term Care agency, which certifies eligibility for both in-home services and nursing home placement in South Carolina. Only community-dwelling older persons who needed assistance with one or more instrumental activities of daily living, and/or with one or more activities of daily living were selected for this study, because such impairments present older persons and their families with decisions regarding how the older person should be assisted, and whether or not to enlist the assistance of formal care services.

Because the care recipient usually plays an important role in the family dynamics and caregiving decision-making processes, and because elderly care recipients are often excluded from family caregiving research, every effort was made to include the elderly person in this project. However, it was possible to interview only four older care recipients. Most of the others had short-term memory problems that rendered their answers unreliable. One person receiving assistance refused to be interviewed. In another family, the members interviewed agreed that interviewing the care recipient might create difficulties because she did not view herself as dependent on others for assistance, though she clearly was receiving help from them. They did not want her to be interviewed.

When the family met the eligibility criteria for participation in the study, either the primary caregiver or the care recipient was asked to invite as many family members as possible to participate in an individual interview. When names and phone numbers of potential participants were furnished, I called them to explain the project and confirm their interest in joining the study. Each individual gave written consent for his or her participation in advance of completing the interviews.

Incentives offered to encourage persons to participate in this project included an explanation of services available to caregiving families in their community, information on how to access these services successfully, a brochure listing all services for senior adults and their families in the area, and $10. While all families eagerly accepted the brochures and the opportunity to discuss community services, only a small percentage of interviewees accepted the money offered to them.

Data Collection Procedures

Before each interview began, I gave each participant a University-approved consent form, which explained the purpose of the research, affirmed that participant identities would be kept confidential, and explained the possible risks and benefits of the research. No one was interviewed without giving informed consent. A summary of the research results will be mailed to each participant in the study.

The interviews were conducted in the setting preferred by the participant. In most cases, the home of the interviewee served as interview site. Several participants were

interviewed in their business offices at their request. All interviews were conducted at times convenient to the participants, and included evenings and weekends.

Semi-structured interviews consisting of approximately 20 questions were used to answer the research questions. The interview began with inquiries about the respondent's opinion of the part families should play in providing assistance to the older family member who currently received help, followed by a question about how much their beliefs were shared by others in the family. These questions were designed to stimulate respondents' thinking about family caregiving, elicit their beliefs about family responsibility to older members, and compare and contrast their beliefs with those of other family members to be interviewed later. These questions were followed by questions about the evolution of the current caregiving situation, the respondent's role in caregiving, factors that influenced the respondent's sense of responsibility, factors that led to the use of formal care services, and possible changes in feelings of responsibility for the older person when formal care services were used. Appendix A contains the full list of questions asked in the interviews.

At the conclusion of the interview, each participant completed a short questionnaire that solicited mostly demographic data. Appendix B contains a copy of the questionnaire. It was developed and modified from questions suggested by McCracken (1988).

Questions about respondent perceptions of the ideas and beliefs of those family members not present were asked in these interviews. Wright (1990) defined this type of

questioning as an adaptation to family research of the circular questioning techniques of Milan systemic family therapy (Fleuridas, Nelson, & Rosenthal, 1986). By asking these questions, additional interpretations were elicited, as well as conflicts or disagreements among family members in the area of perceived responsibilities for providing assistance to the elderly person.

Many of the interview questions contained probes that were designed to obtain greater depth of information about the primary areas of interest. In addition, use of these probes led to one or more additional questions that facilitated the discussion of issues important to the family in defining their caregiving patterns and processes.

In all families, the primary caregiver to the older person was interviewed. Several researchers have found that one family member generally assumes primary responsibility for caregiving responsibilities (Brody & Schoonover, 1986; Cicirelli, 1992; Horowitz, 1985; Matthews & Rosner, 1988), and that the motives for such behavior range from love, feelings of family ties, and feelings of duty and obligation to unavailability of other family members and family tradition (Guberman, Maheu, & Maille, 1992).

Other individual interviews were pursued on the basis of the following criteria: the recommendation of the primary caregiver or care recipient, the caregiving roles of additional family members, and the opportunity to explore the potential for intergenerational transmission of filial responsibility and values related to caregiving in each family.

A total of 43 persons were interviewed; 40 interviews were conducted with individuals and 3 with family groups. The interviews ranged in length from 45 minutes to 2 hours and 15 minutes. All interviews were audio-tape recorded and transcribed verbatim by myself or by hired assistants whom I trained. All persons hired were experienced medical transcriptionists who needed minimal training. I proofread all interview transcripts by listening carefully to the audiotapes while reading the transcripts. Errors in the transcripts were corrected prior to final printing and data analysis.

Notes of my observations about the interview content and process, as well as personal reactions, were made immediately after each interview session and were analyzed in conjunction with the interview data. A contact summary sheet (Miles & Huberman, 1994) was prepared prior to each interview, and completed as soon as possible after the interview was concluded. All contact summary sheets were completed within 24 hours of each interview. This sheet contained several questions that helped to summarize the important points of each interview and raise issues for further consideration in subsequent interviews. A sample of this sheet is located in Appendix C.

Data Analysis Process

Analysis of the interview data followed a process of modified analytic induction (Bogdan & Biklen, 1992). Gilgun (1995) described the goal of modified analytic induction as "developing descriptive statements of relationships among concepts (p. 278)." She noted that such analysis makes no claim of universality. What distinguishes it from the analytic induction of grounded theory (Strauss & Corbin, 1990) is that

hypotheses about relationships among concepts are developed before the research is conducted or before the data are analyzed (Gilgun, 1995). In this research project, I had developed some ideas about the relationships among constructs, along with their relative importance in family caregiving, that I wanted to explore. I revised my thinking as I carried out the analysis. The actual stages of data analysis followed the process of discovery of analytic categories described by McCracken (1988) in The Long Interview. First, I read the interview transcripts twice; the first time for content understanding; the second time for identification of useful utterances noted as observations. At this stage, I did not relate these observations to other parts of the interview text. Second, I developed my observations into expanded observations based upon evidence presented in the transcripts and the relevant literature. Oft-repeated phrases and words were an area of special focus, as they provided clues to meaningful data. I developed some preliminary descriptive and interpretive codes at this stage.

In the third stage, I examined the expanded observations, searching for and identifying their connections to each other. My search was guided by the literature review, conceptual framework, and hunches developed from previous readings of the interview text. Patterns that emerged from the data were identified and pattern codes developed for further analysis.

The goal of the fourth stage of analysis is to determine patterns of intertheme consistency and contradiction (McCracken, 1988). I accomplished this objective by examining clusters of comments, including memos made about certain passages in each

interview transcript. Basic themes were generated, refined, and organized hierarchically into major and minor themes. During this stage, further examination of the data occurred continuously.

Finally, I examined the identified themes for all interviews within a given family, and across all families, to determine theses or propositions contained in this data set. My conclusions and supporting evidence derived from the data are presented in the next chapter.

Data were coded and analyzed with use of the qualitative software QSR NUD*IST 3.0, power version™ (Richards & Richards, 1995). With a data base of 40 interviews, the process of data analysis was lengthy; however, the use of this software package enabled a thorough, efficient analysis to be conducted.

Reliability

Kirk and Miller (1986) described reliability in qualitative research as the detailing of "the relevant context of observation" (p. 52). Both the ways in which researchers arrive at the methods they use and statements about their personal feelings and experiences during the research process are needed. Such information was recorded on the contact summary form and in a personal journal kept from beginning to end of the research project. This journal, as suggested by Spradley (1979), contained my experiences, ideas, fears, mistakes, confusions, and breakthroughs, as well as a description of problems that arose during the project. The journal entries were reviewed periodically during the research process, but especially during data analysis and write-up

of the results. Journal entries assisted me in the development of themes and explanations for the study's findings. This document served as a learning tool for me, and might be useful to a researcher interested in replicating this project.

As a means of obtaining critical review during the data collection and analysis processes, I met frequently with my committee chairperson. We focused upon challenging aspects of the data collection process, including which participant families to include or exclude from the data analysis process. We reviewed the emerging analytic categories for revision, as well as possible areas for focus in the discussion chapter of this document.

Chapter IV: Results

The purpose of this study was to explore how families who care for their aged parents at home develop a sense of responsibility to their parents, how members of the multigenerational family fashion their caregiving roles, and how performance of these roles and perceived responsibility are affected by the use of formal care services. Research questions examined the meaning of responsibility to the older person, the ways in which such responsibilities are learned, and the thinking of respondents about caregiving behaviors to which men and women were best suited. Additional research questions investigated how feelings and interpersonal family ties shaped family members' sense of responsibility to the older person, as well as their use of formal care services. Finally, the question of how feelings of responsibility were affected by use of formal services was probed.

The chapter begins with a description of the study's participants. Answers to each research question are presented in turn. All proper names in the quotations are pseudonyms.

Overview

The study results are based upon 40 interviews with members of 15 families. Thirty seven of the interviews were with individuals and three were with groups. I interviewed at least two members of each family; the maximum number of interviews in any family was six. The modal number of interviews per family was two. A total of 43 persons participated in the study, 15 men and 28 women.

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The families currently cared for 17 older members, with two families assisting a husband-wife couple. Care recipients were primarily female: only 3 of the 17 were male. In addition to the parent, two families were currently caring for adolescents with mental disabilities. Two other families had responsibilities for an additional parent who was in a nursing home. Three other families had cared for a second older relative at home until recently. Thus, most families in this study were experienced caregivers, and accustomed to assisting several family members simultaneously.

All primary caregivers in this study were female; most were daughters. Among other primary caregivers were several daughters-in-law and one granddaughter. The families in this study were well educated, with only three respondents lacking a high school education, and over half with college educations or advanced degrees. The majority were married. All but one respondent listed a religious preference, and 39 ranked spirituality as very important. The majority listed Republican for their political party preference. Religious and political orientations were sought because they comprised two components of Brubaker and Brubaker's formulation of individual and family ethos. These demographic characteristics of participant families, as well as information on residential status of the parent and sibling availability to assist in parent care, are contained in Tables 1, 2, and 3.

The respondents in the study represented all stages of adulthood. The youngest person interviewed was 19; the oldest was 93. The age range for care recipients was 67

Table 1. Selected Characteristics of Families with Two Respondents

Family	Relationship to Care Recipient	Educational Attainment	Marital Status	Religious Preference	Importance of Spirituality	Residential Status of Elder	Sibling Available to Assist
A	care recipient daughter	busnss college eleventh grade	divorced divorced	Baptist Episcopal	very important very important	in own home	Yes
B	daughtr-in-law son	college grad college grad	married married	None Methodist	very important very important	in child's home	No
C	daughter son-in-law	master's degree (both)	married married	Presbyterian Presbyterian	very important very important	in child's home	No
D	daughter granddaughter	high school graduate (both)	divorced married	Baptist Baptist	very important somewhat impt.	in child's home	Yes, but unwilling
E	daughtr-in-law son	college grad master's deg	married married	Catholic Protestant	very important somewhat impt.	in child's home	No
F	daughter son-in-law	master's degree (both)	married married	Presbyterian Presbyterian	very important very important	in child's home	No
G	care recipient daughtr-in-law	G.E.D. eleventh grade	widowed married	Baptist Baptist	very important very important	in own home	Yes, but unwilling

Table 2. Selected Characteristics of Families with Three Respondents

Family	Relationship to Care Recipient	Educational Attainment	Marital Status	Religious Preference	Importance of Spirituality	Residential Status of Elder	Sibling Available to Assist
H	care recipient daughter granddaughter-in-law	college grad some college some college	widowed married married	Methodist Methodist Non-Denomnatnl	very important very important very important	in child's home	No
I	daughter son-in-law grandson	college grad Ph.D. college grad	married married single	Baptist Baptist Baptist	very important very important very important	in child's home	No
J	granddaughter daughter son-in-law	high schl grad college grad college grad	married married married	Assembly of God (all three)	very important very important very important	in own home	Yes, but unwilling
K	daughter-in-law son daughter	high schl grad. G.E.D. high schl grad.	married married widowed	Pentecostal Protestant Non-Denomnatnl	very important very important very important	in own home	Yes
L	daughter son-in-law son	college grad advance deg. college student	married married single	Lutheran Lutheran Lutheran	very important very important somewhat important	in child's home	No

Table 3. Selected Characteristics of Families with Four or More Respondents

Family	Relationship to Care Recipient	Educational Attainment	Marital Status	Religious Preference	Importance of Spirituality	Resident Status of Elder	Sibling Available to Assist
M	care recipient	third grade	widowed	Catholic	very important	in child's home	No
	daughter	high schl. grad	married	Catholic	very important		
	son-in-law	high schl. grad	married	Lutheran	somewhat impt.		
	granddaughter	associate degree	married	Presbyterian	very important		
N	daughter	high schl. grad	married	Non-Denominatl	very important	in own home	Yes
	daughter	one year college	married	Baptist	very important		
	granddaughter	college grad	married	Christian	very important		
	granddaughter	college grad	married	Christian	very important		
O	daughter-in-law	college grad	married	Methodist	very important	in own home	Yes
	son	college grad	married	Methodist	very important		
	son	college grad	married	Presbyterian	very important		
	grandson	college grad	married	Presbyterian	very important		
	grandson	college grad	married	Presbyterian	very important		
	granddaughter	college grad	married	Methodist	very important		

to 100 years. Ages of their adult children and children-in-law ranged from 44 to 70 years old. Grandchildren ranged in age from 19 to 42 years old. The average ages for respondents by type of caregiver are presented in Table 4. Table 5 presents age data by each generation of respondent.

<div align="center">Research Question One: The Meaning of Caregiving</div>

The first research question explored the meaning of responsibility in caring for an older family member. Family members' responses to the older member's need for help were guided by their definitions of the nature and extent of personal and familial responsibility. How families defined their responsibilities helped to shape what they did for the older member, and what they engaged formal service providers to do. Figure 1 displays the themes that emerged from this analysis.

Family members described the meaning of responsibility to an older family member in two ways: responsibility to the older person and responsibility to the family as a whole. The next sections delineate these two general categories in detail.

Responsibility to the Care Recipient

Three broad themes emerged from the data describing responsibilities to the person receiving assistance: environmental quality, sensitivity, and inclusion.

Environmental quality. Environmental quality described caregiver provision of a physical environment in which the safety and the comfort of the older person was paramount. Issues of safety were discussed in 35 of the 40 interviews, and sometimes

Table 4. Ages of Family Members by Role in the Family

Role of Family Member	Number	Age in Years	
		M	SD
Care Recipient	17	85	8.2
Primary Caregiver	17	54	8.2
Secondary Caregiver	16	49	14.1
Occasionl Caregiver	6	36.5	8.8

Table 5. Respondent Ages by Generation of the Family

Generation	Number	Age in Years	
		M	SD
G1 Grandparent	4	85.5	5.3
G2 Parent	28	55.5	6.8
G3 Grandchild	11	33	8.1
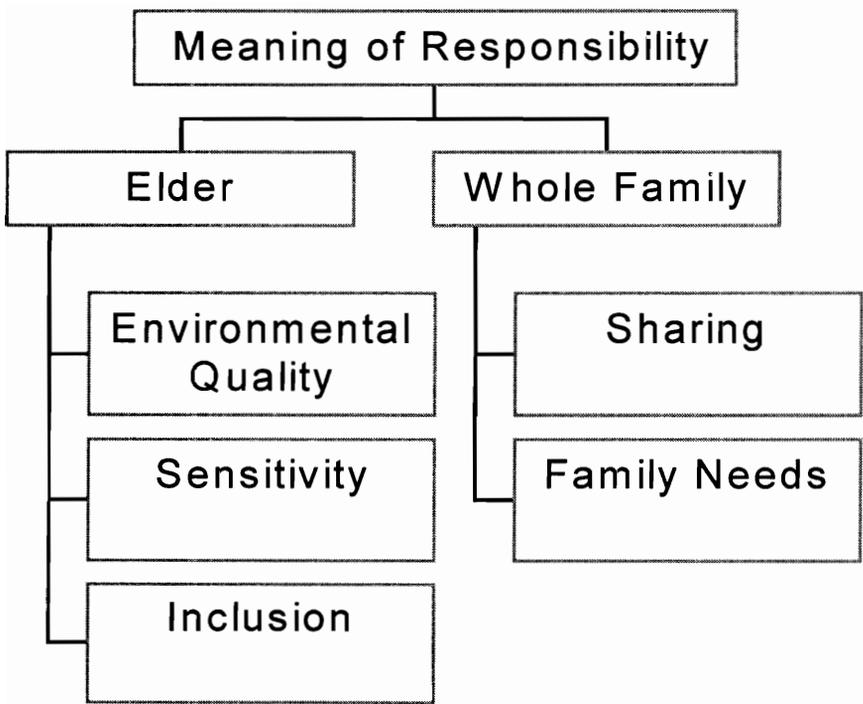
Figure 1. The Meaning of Responsibility

linked to issues of personal autonomy for the older parent. One caregiving son described safety issues in the following way:

I really thought a lot about the balance between her desires and her safety over that four-year period, and then have sort of taken a series of actions along the way, trying to favor as much as I could what I knew that she wanted, and at the same time...not to risk too much from a safety standpoint.

All but four respondents indicated that it was important to make the older person's environment comfortable. When the older parent lived with a child, the home was customized to make it safer and more comfortable for the elderly parent. Other families decorated the parents' rooms with mementos and collectibles treasured by parents in an effort to make it more like home to them.

Sensitivity. Sensitivity to the needs of the older parent was also a prominent theme in the families' accounts of what it meant to be responsible to their older members. In this study, family members demonstrated sensitivity in three areas: concern for maintaining the older person's autonomy for as long as possible, engaging in parentalism as needed, and attending to the care recipient's emotional needs.

Preserving personal autonomy was a concern of caregivers and care recipients alike. An interview with a mother-daughter pair in a situation in which the mother needed assistance with only instrumental activities of daily living yielded the following exchange:

Daughter: My belief is to let them do what they can as long as they can.

Mother: That's certainly the way I feel about it. Let me do...I dread the time when I have to leave...when I can't live alone. I dread it.

On the other hand, when older members clearly showed an inability to make sound judgments, family members were willing to step in and take that responsibility. Parentalism, a term derived in the context of ethics (Beauchamp & Walters, 1982), was eloquently defined by a grandson as follows:

...when you interject yourself into someone else's life...and are trying to protect them in a way. It's a relationship change. You're used to being the junior partner, the subordinate, and all of a sudden you're stepping forward and say I need to take charge of the situation and I'm going to have to make a tough call, and I'm sorry about this; I'm really doing this for your best interest.

His aunt, who had assumed the role of primary caregiver to his centenarian grandmother, said it succinctly:

...well, she's not able to call the shots, so I will.

The families in this study did not step in to make decisions until there was evidence that their older relatives could not make them for themselves, and most did so in consultation with siblings and other important family members.

Meeting the emotional needs of older family members involved such behaviors as preserving their dignity by refraining from saying or doing things to hurt their feelings,

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calming their fears, joking with them, and talking about times past and good memories. A grandson described his efforts in this manner:

> One of the things I try to do when I go by is, not so much talk about the present, because a lot of times the present, is not a very positive thing...so I try to focus on the past, and what I try to do is just talk about things that provoke memories, and hopefully, good memories. Times she visited when we were young; things they did for us when we were young. Talk about my grandfather; you know, the way things used to be.

Several caregivers mentioned how difficult it was for their parents to be so dependent on them for assistance, and that by putting themselves in their parents' shoes, it helped them to cope with demanding or difficult parental behaviors.

Inclusion. Whenever possible, family members included the older person in their lives. They outlined four important means of including the older person: by visiting them, by showing them affection, by involving them in daily activities, and by taking them on outings.

Visiting older relatives living in their own homes was discussed in 37 interviews. A son who visited his mother every day described his feelings in this way:

> The older family members need to be noticed. They need to be visited. They need to be talked to. If you just spend five minutes with them, that kind of shakes their day up a little bit, and lets them know that you care. I think that the biggest thing you can let them know is that you still care about them.

Intergenerational relationships were enhanced by visits to homebound relatives. A granddaughter-in-law described her children's visits to their great-grandmother as follows:

> And the kids have got their part too. You know, they go in and cheer her up, and say hello, and Don's kind of got a special place in great grandma's heart. He'll go in and she'll rub his back...and he just kind of melts.

Affection was described in the contexts of behavior towards the older person, or in the older person's need to touch and be touched by others. As she told the story of how she made the decision to care for her stroke-impaired mother-in-law, one caregiver related the following:

> I could tell she was really sick. It really scared me for her and I can remember just putting my arms around her and it just came to me that I'm really willing to take care of her and see her finish the rest of her life. I just didn't want her to be alone anymore.

In addition to affection and visits, families included their relatives in a variety of daily activities. Among the favorites were conversations, eating meals together, family gatherings to celebrate birthdays and holidays, and reading to them. One respondent read Sherlock Holmes mysteries to his father-in-law frequently.

Outings were special activities in which families included their dependent older members. From short drives to lengthy cross-state trips to visit other relatives, over half of the study respondents described the importance of taking their loved ones on outings.

Responsibility to the Whole Family

Responsibility to the extended family was conceptualized by respondents in two ways: sharing of responsibilities for care provision among family members and considering the family needs in defining the extent of responsibility to assist the older member.

Sharing. Sharing the provision of assistance among several members was described as a familial responsibility in all families, regardless of whether or not it occurred in the family. The families in this study were split almost evenly in caregiving constellations. Eight families relied primarily upon one member to carry out the majority of tasks, including the arrangement of services performed by agencies or home care workers. Seven families had two or more members who performed caregiving tasks regularly; of these, two families split responsibilities equally; the others split responsibilities in various ways.

Families also differed with respect to their degree of satisfaction with the current care arrangements. A primary caregiving granddaughter who received routine assistance from her parents and spouse with her grandparents described her situation as follows:

There again, it's just who gets there first, you know. So I think we just kind of all do it together, you know, and I think we'd all be crazy if we didn't help each other.

Her father summarized their arrangement by saying:

...if they don't do it and I see it needs to be done, if I don't [do it myself], I'll get somebody to do it [housekeeping and yard chores].

Her mother echoed this stance:

> ...sharing responsibility and all. I just...it's just something we do.

This family was very comfortable with the division of caregiving labor, as they had developed a system that worked for them. It was interesting to note that they described themselves as servants; the father's profession was the ministry, the mother's was nursing, and their daughter's was homemaking.

In contrast, two of the families with multiple siblings were characterized by one sibling carrying <u>all</u> the responsibility for the parent. One caregiving daughter in this situation stated her opinion of it:

> I think it should be shared, I always have, but you know, it does not always work out that way, and I am the type of person that, whether the responsibility is shared or not, it is still there. And if nobody else wants to, that is irrelevant, it still has to be done.

She related an incident typical of her attempts to get others to share responsibility for her mother:

> A lot of times I will call one of my sisters. My sister that gets off at 3 o'clock; I get off at 3:30. If I call her to take Momma, she doesn't like it. She'll have a fit. Last time she said it was my turn. So the next time I didn't even call her. I've got to where I don't even bother 'em.

Families were quite diverse in both their caregiving arrangements and their level of satisfaction with those arrangements. However, all families expressed the desire for sharing as part of the familial responsibility to the dependent older member or members.

Family needs. The particular family needs were also considered in defining what it meant to be responsible in a caregiving situation. Issues such as the presence of minor children in the home, the need for two wage earners in a family, or the presence of a very disruptive older person in the home were cited as circumstances that shaped the definition of familial responsibility to an older member who needed assistance. This theme was articulated in 34 of the 40 interviews. One caregiving daughter summarized this theme nicely:

> I think that we should be involved in helping an older person as long as we can without totally destroying ourselves. I think we have to understand that we probably have a husband, maybe children still in the home, and we need to provide as good a care as we can, for as long as we can, unless, until the point we see that it's hurting relationships in the family, or that we can no longer care for the person, physically, financially, or emotionally. And then we need to seek help.

Nearly every family in this study felt that there were some limits to caregiving responsibility. Prominent among those limits was the sanctity of the marital bond. Many respondents asserted that caring for a parent should not occur at the expense of the

marriage, although most families tried to find ways to accommodate and nurture both relationships.

In summary, families defined the meaning of responsibility in a two-fold manner: to the older members and to their families as a whole. Responsibility to the older person included more than provision of a safe and comfortable environment; it encompassed emotional support in the form of sensitivity to the parent's feelings and desires for independence, as well as inclusion in family activities. Responsibility to the whole family meant sharing caregiving activities among family members, and making caregiving decisions with the entire family's welfare in mind.

Research Question Two: Learning Responsibility

The second research question consisted of a general question that asked how families learn what they are responsible for in caring for an older member in a non-institutional setting. Family members learned their responsibilities through a variety of experiences; some within and others outside of their families. They learned through the expectations of family members, through the modeling of caregiving behaviors by family and friends, and through a process of role making. Figure 2 presents these results in diagram form. Each of these themes is now discussed in turn.

Family member expectations

When applying symbolic interactionism to role performance within families, it is important to examine the expectations of family members regarding who should
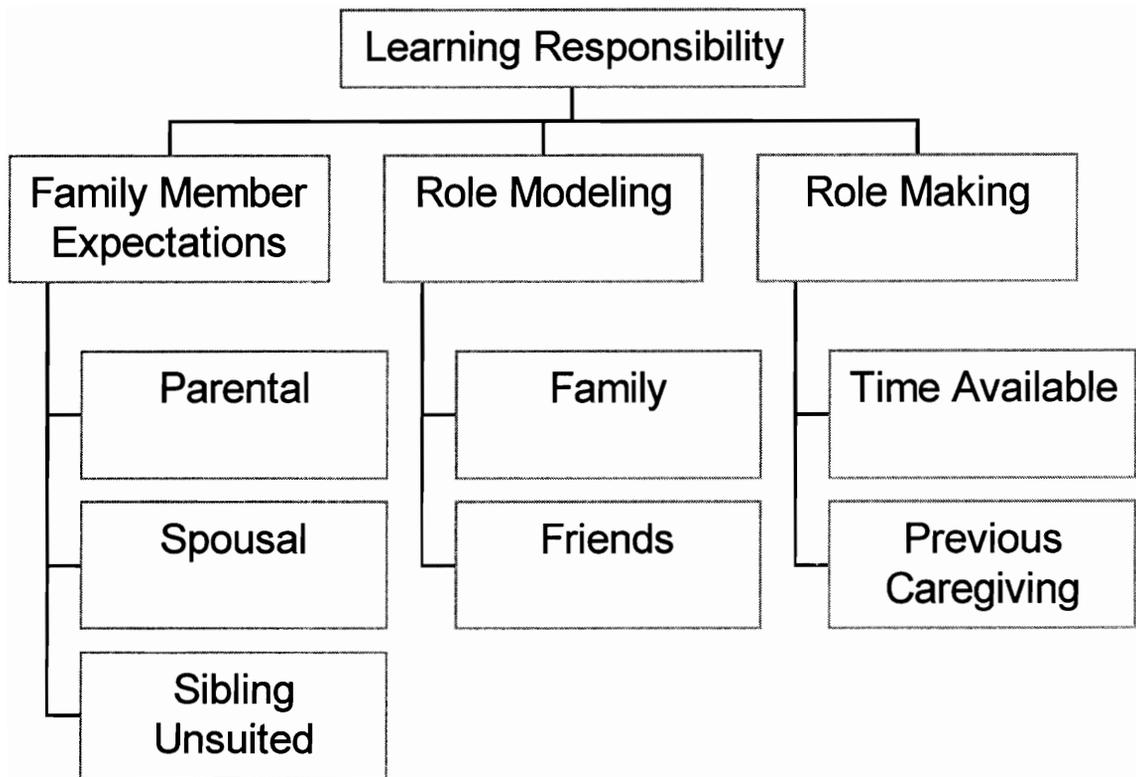
Figure 2. Learning Responsibility

perform a given role, and how that role should be carried out (Klein & White, 1996).

Expectations of children expressed by parents were dominant among the ways that families learned their caregiving responsibilities to older members. A summary of parental expectations is provided in Figure 3.

Parents sometimes stated or implied their wishes for filial care. A daughter serving as primary caregiver recalled her mother's edict at the time of her father's death:

> ...when dad died, she pointed a finger (and he hadn't been dead two seconds), and she said "Jane Clay"; she pointed her finger right straight at me, "now you will take care of me." She told me, you know.

A care recipient related the story of how her son and daughter-in-law became her primary caregivers:

> I didn't know it when it happened, but my son told me that his dad called him in the bedroom and asked him, says, "when I'm gone, look after your mother," and I think that's had a bearing on it.

In some families, the communication was less direct, but nonetheless, effective in accomplishing the goal of teaching filial responsibility. A daughter who cared for her mother said:

> My father died in '86, and it was almost like we had planned for mother to live with me. My mother never spent one night in that house without me. From the time my father died, she closed the house up, and she came home with me.
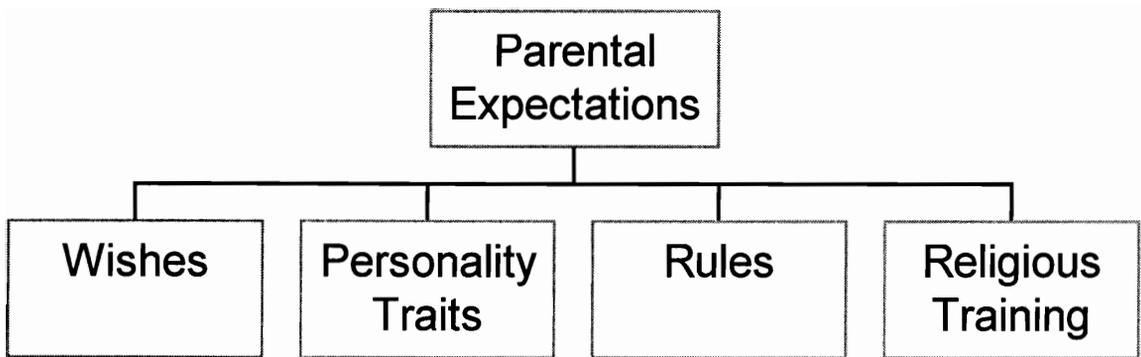
Figure 3. Parental Expectations

In addition to stated or implied wishes, the personality traits of some of the care recipients contributed to the learning process of their caregivers. Parents with a dependent personality were perceived as exerting pressure on their children to care for them. The caregiver of the youngest parent in this study described her mother in the following manner:

> Momma is the type that tends to want you to take care of her. She always has. She does not like to think for herself. She wants you to do everything. If she starts to itch she wants to know what she should do about it; is there some medication for it....yes, I am her security blanket.

Children found it difficult to resist parental pressure to be caregivers, even when they thought the demands of their parents were excessive or unreasonable. These conditions sometimes fostered resentment, expressed by one daughter who concluded:

> I don't really feel like I was ever a child. I grew up in an adult family as an adult.

Many families had rules about behaviors that guided how respondents learned about caring for older family members. Chief among those rules were: be selfless when faced with others' needs, families take care of their own, and look after your parents as they age. These rules were mentioned in 25 of the 40 accounts. A grandson summarized his interpretation of his family's rule about caring as:

> You're just tied to your family. And you're not going to walk away from your family whatever the circumstances are.

The final parental expectation was the religious training that was part of the respondent's upbringing. Religious training was very robust in this sample; it was mentioned by 27 interviewees. Family members connected their early religious training to what they learned about caring for parents and about treating one another. A daughter said:

> ...from the time you're coming along...we hear one of the commandments, "Honor thy father and thy mother that thy days may be long upon the earth." And I suppose being ingrained into us, that during my father's illness, long years of illness, many times the church itself was very responsive to our needs. They called, they prayed, they cared. And I know that has helped shape me...

Many respondents incorporated their religious upbringing into the practice of their religious faith as adults. They manifested filial responsibility by linking their expectations of themselves with the practice of their religious faith. One daughter described this link in the following manner:

> I am a great believer in the life of Jesus Christ and his example. The servanthood. The entire ministry of Jesus; he was a servant. So I believe in that. What I'm saying; it's a matter of self-denial, which goes back to the Bible. In my...what I see.

In addition to parental expectations, spouses' expectations of their partners were noted as important by 30% of the respondents. Two themes emerged in this area: the decision of how to care for a parent who needed help and the division of caregiving labor

between spouses. The issue of dividing the caregiving labor sparked some interesting comments. A daughter-in-law caregiver described her situation in this way:

> I had to discuss it with him. I went along for quite awhile just thinking, "Well, he's going to pick up on it" and then I realized the best way is to say, "This is what I need you to help me with--a, b, c, d, e." And so that's what I did. I'm making it sound like it just happened so smoothly, but it didn't. We had to have several conversations and I got very emotional.

Her husband described the situation by saying:

> She'd say, "Well I want you to take care of mom for an hour," or "Fix the wheelchair," or "Do this to the car," or "Do this." So, I started on the list, and the thing I didn't get to was mom, and then we had conversation after that. So, I wouldn't call it bargaining, it was just trying to keep me lined up to do what I'm supposed to do...

Spousal expectations were most important in families in which the two spouses performed all the caregiving labor. In these families, siblings were usually unavailable, and children were grown and living away from home.

However, even when siblings were located nearby, primary caregivers were not always able to rely upon their assistance. Members of three families had difficulties getting siblings to share caregiving responsibilities. In two of these families, alcohol abuse was mentioned as a problem with one or more brothers.

To summarize thus far, the expectations of parents, spouses, and siblings were one means by which family members learned what they were responsible for in providing assistance to an older family member. Two other ways in which family members learned responsibilities were role modeling and role-making.

Role Modeling

The modeling of caregiving behavior by family and friends was a powerful means by which family members learned caregiving behaviors. All families in this study recounted one or more instances in which family had cared for other elderly family members. In some instances, they recalled how their parents cared for their grandparents. One of two sisters who currently shared responsibility for their mother's care said:

> I was just brought up in a family (we were close) and my grandmother lived with us, she had heart trouble, but she was very agile--to the day she died, she was able to get around. And she never lost her memory capacity that has happened to her daughters...so I guess being raised with her in our home a good part of my life, it was just a natural thing that this is what you do. You know, families look after families.

Her sister agreed:

> I think my grandmother had a lot to do with it, and my mother, too. When she [grandmother] got ready to be taken into a home...nobody would have her but my mother and dad. So I have to admire them...

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Several respondents learned from their relatives that there were limits to providing care in a noninstitutional setting. A respondent whose mother-in-law currently resided in his home along with an adolescent son who had Down's Syndrome related an incident in his own family:

> I have never believed in dumping people unless there's no real alternative. My aunt was institutionalized. I know it was one [decision] the family agonized over and just didn't feel like they had any other choice. They tried and tried...she drove everybody crazy and everybody finally said "What are we going to do with her?" and there are places for people like that to go and we just have to decide to send her there.

Several grandchildren noted that their parents were teaching them how to assist them later in the ways that they cared for their grandparents now. A grandson related his view:

> We're now to the point where I'm watching how my parents take care of their remaining parents; their mothers in this case...so, I think I'm being influenced at the present time and probably formulating some of the ideas that will affect me and maybe how I take care of my parents, when that time comes.

Modeling of caregiving behavior was not limited to that of family members; friends also influenced what respondents learned about caring for older family members. Nearly 40% of the respondents described an incident in which a friend cared for an elderly relative in a noninstitutional setting. A woman providing considerable help to her stroke-impaired

mother-in-law at home spoke of the role her friend's behavior played in her own caregiving decisions:

> I had a very close friend who took her mother in to live with her several years ago, and at the time, they had a very busy lifestyle. I couldn't see it working at all. When I saw my friend with two teenagers accommodate her mother...I thought, this is not...this is very doable...this is possible. So when you see something like that...

Taken as a whole, modeling caregiving behavior by both family and friends was a considerable influence on what families learned about caring for their own elderly relatives. No other category of influence was mentioned as frequently by the study's respondents. The intergenerational nature of this influence is also important for scholars to recognize. It is one of the legacies that family members bestow upon one another.

Role Making

Role-making is a term coined by symbolic interactionists to denote the idea that when persons are in the process of enacting a role, they create and modify the role to make it more explicit. As family members are faced with decisions about providing assistance to an older member, they define what their caregiving roles are and are not. Half of the study respondents described the process of role making in their interviews. Spouses often defined their roles in relation to each another. The amount of communication needed to explicate these roles varied among couples. The following

exchange occurred between myself and a couple, interviewed together, who were caring

for the wife's mother:

> Mrs. J: He'll do that, or he'll see I'm doing one thing, and he'll just pick up and do
> what I'm going to do next.
>
> K: Oh, OK. Like an assembly line.
>
> Mrs. J: It's more of a spontaneous action.
>
> K: So, now, how do you recall it?
>
> Mr. J: We'll do it together. I'll say "Do you have anything for me to do?" and
> she'll tell me, or I just see it has to be done, and...
>
> Mrs. J: Mostly, he just sees it has to be done.
>
> Mr. J: She's been doing all of the lifting of her, though, in and out of bed. I hurt
> my back four or five months ago.

A few primary caregivers tried to do everything while hoping their spouses would see

they needed help and rescue them. Eventually, they asked for what they wanted, and got

help. A woman who cared for her father said:

> ...step by step, the load got heavy, and I said "Can you help me?" And, he would
> see...lots of ways he could help and would.

A few families who were providing assistance to older members had been doing

so for several years. Their roles had become so explicit that they felt no need to

communicate them to one another. The members of one such family maintained that they

had not felt the need for such communication:

We never discussed it. We just did it. I mean, we just did what needed to be done. My daughter has three children, but she doesn't work outside the home, and everybody went about doing what they thought they needed to do. We never sat down as a family and said well, you need to take them to the doctor. We never did that.

On the other hand, a family with three full-time workers, two parents and their grown son, discussed their activities frequently and defined their caregiving roles according to who had time available to assist the care recipient with her needs. Their roles were fluid, moreso than most families interviewed for this study.

The enactment of the caregiving role was modified by several caregivers in this study. Roles were modified according to changing needs of caregivers or care recipients. Two daughters who shared caregiving responsibilities on weekends for their mother and aunt, who lived together and had Alzheimer's disease, changed their arrangement when one of them became overly stressed:

We just talked about it like I said earlier. We did our six months of caregiving, and before I was through with that, I knew this would not happen again, and she's going through hers now and it's really been tough on her. So then we just talked, and said let's try two months. So...that's going to be our next goal...to take two months at a time.

A couple of primary caregivers defined their role in relation to siblings and relatives who wouldn't help them: A daughter-in-law said:

...a lot of times, they won't help. She'll call and they hurt her feelings. I'll tell her not to bother 'em, just call me or Don and we'll take her...

Thirty percent of the respondents in this study used their previous experiences as caregivers to assist them in the role-making process. Some had helped care for grandparents during their childhoods; others had cared for a now-deceased parent, and used that experience to guide their care for a relative who currently needed help. A daughter-in-law summed up her prior experience in the following manner:

I guess maybe going through the experience with my mother early on, with knowing that she needed care because she had this health problem, and I guess, it just kinda falls on the women in the family really...

Training for elder caregiving was not limited to the middle generation of adult children; several grandchildren had already provided assistance to relatives, including their grandparents. One 24 year old granddaughter had already given short-term assistance to her mother, father, and mother-in-law during medical rehabilitation periods. She was currently preoccupied with her nine-month old twins, but anticipated a long life of caregiving in the future.

In summary, family members had learned a considerable amount about their caregiving responsibilities by the time they reached adulthood through observation of other members as role models. Their roles as caregivers continuously evolved through role-making, the process of responding to their own changing needs, as well as the

perceived needs and expectations of other family members. The next section of the results chapter examines the division of labor by gender among respondent families.

<u>Research Question Three: The Gendered Division of Labor</u>

In this study, respondents were asked questions about the division of caregiving labor designed to elicit information about both thought and behavior patterns. Respondents described what they did and what others did for the person receiving care. They also discussed who they thought was best suited to provide assistance to the care recipient. A summary of their responses is depicted in Figure 4.

<u>Behavior Patterns</u>

When defined as performance of hands-on tasks, caregiving labor among respondent families followed a traditional gender role division. Men did the home and lawn maintenance, and usually managed the care recipient's financial affairs; women did the housekeeping and personal care tasks, such as bathing and toileting. There were a few exceptions; the men in one family assisted with personal care tasks occasionally, and the husband in another family did substantial amounts of cooking while his wife assisted her mother with multiple personal care tasks. However, when the need for assistance
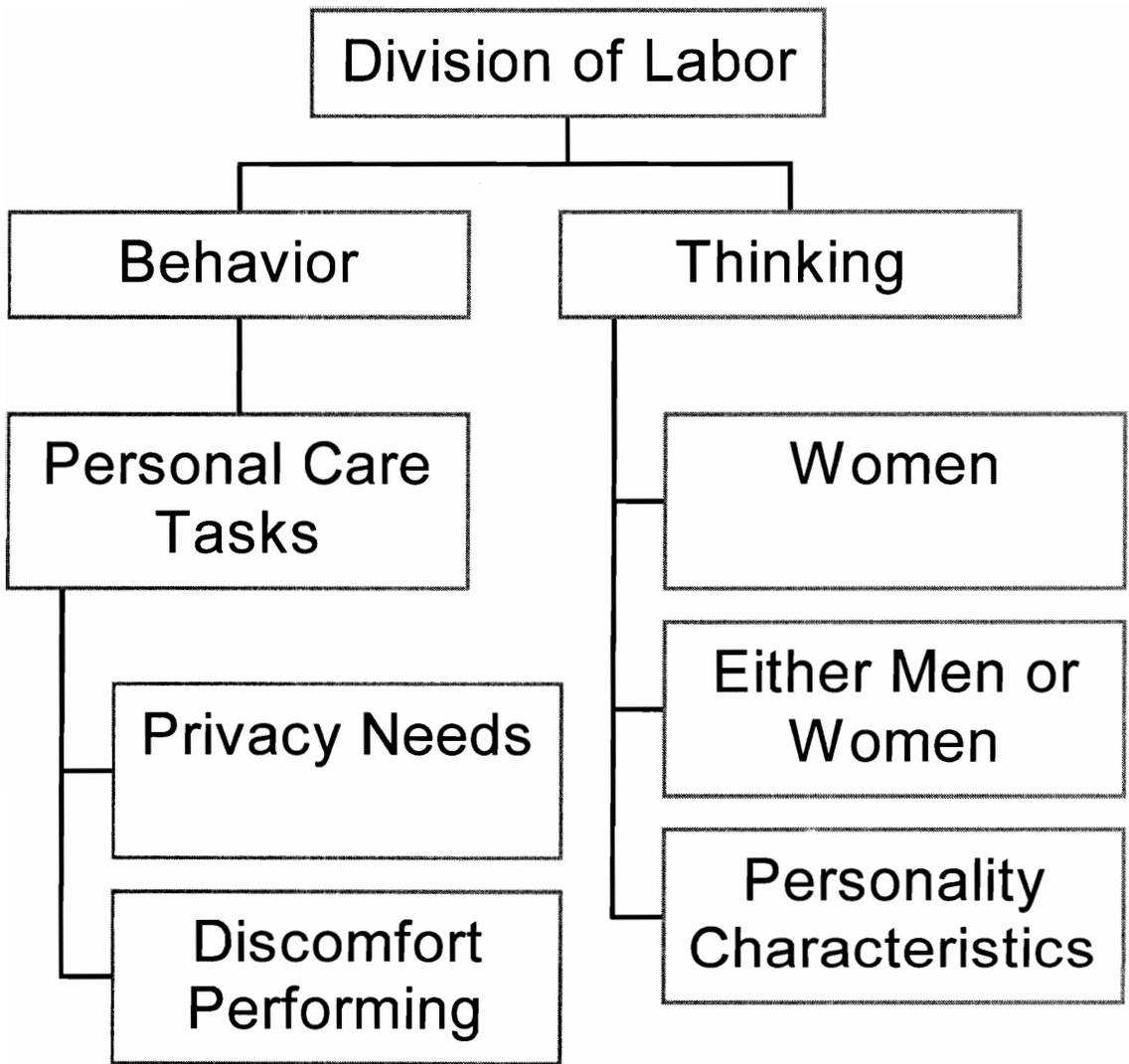
Figure 4. Division of Labor

with personal care was present, most respondents had strong feelings about who should be called upon to help. The next two paragraphs detail their responses.

Respondents talked about the privacy needs of the care recipient, and about their or others' discomfort with helping a family member with personal care. Responses in each of these categories were made by nearly equal numbers of men and women. Those families who were currently helping someone with personal care were most likely to comment upon this issue. Respecting the care recipient's need for privacy was illustrated by this son-in-law's comment:

> For instance, I can't take her to the bathroom and things like that. She feels very uncomfortable. Sometimes I have to go in and help pick her up. She's fallen down...she is embarrassed about that, but we don't have any choice if she is sitting on the floor...

Many respondents felt that sons should care for fathers' personal needs, and daughters for mothers' personal needs. But because all but one care recipient in this study was female, most talk of discomfort focused upon male respondents' discomfort with assisting their female parents, in-laws or grandparents. One son-in-law said:

> I couldn't have done that anyway. I just...I couldn't do that.

A grandson echoed his sentiments:

> I don't think a guy is going to be real comfortable helping his mom or grandmother through a bathroom kind of ritual.

In their families, women performed those roles. The only family in which men assisted with personal care tasks had a pragmatic approach to caregiving. One of the men in this family described it as:

...the realistic approach, it's got to be done, so let's get it done.

It is important to note that the composition of this family included only one female.

Thought Patterns

Because the gendered division of labor in families caring for elderly parents has been documented in other studies, I was interested in exploring how thoroughly respondents had incorporated this division of labor into their thinking. Therefore, I asked participants questions about who was best suited to perform the tasks involved in caregiving, and received a variety of answers. Answers focused primarily on gender and personality characteristics of the caregiver.

Women's nature. Fifteen respondents suggested that women were better suited to take care of the elderly by virtue of their nature. Some called it motherly instinct. A male respondent attributed it to heredity in a very colorful manner:

It's a...a guy goes out to war and half of them are playing and half of them...you know, it's in their make up to do that. And the female would stand there and ask why are you fighting each other, and take care of the other people. So, I think it falls, the plight of; that's not the right word, plight...it's just that we're made that way...we're made differently, and...I think that's in us; it's nothing that we learn.

<u>Cultural expectations for women</u>. Twelve respondents defined women as better suited by virtue of cultural expectations for females in American society. The majority of these respondents were women. A daughter assisting her mother stated:

...they have always had to do it. That's our culture. Is that not our culture?

A son pointed out that:

...it's reinforced in everything we do, from television to...

A daughter-in-law generalized the response of men in her family to all men:

I think they kinda expect them to do it, don't you? I think most men do.

<u>Either gender can provide assistance</u>. When asked who was better suited, however, half of the respondents maintained that either gender could do the job. The reasons given were three: family relationships, the primacy of blood kin ties, and the belief that everyone in a family could learn to be a caregiver.

The nature of family relationships was the reason they most frequently cited of the three reasons that either gender could be well-suited to caregiving. A woman who cared for her mother-in-law described her view as:

I've heard in discussing with other families that not all siblings are particularly close to parents. One may be a caring person and the other one is not. Sometimes sons are better; sometimes daughters. So I think you just have to depend on the individual family. I can't make a generalized statement, I don't think.

Other respondents felt that being cared for by blood kin was best, and a few mentioned both family and blood relations as important reasons why either gender might be better suited in a given situation. A woman receiving care from her daughter described her feelings about differences between daughters and daughters-in-law:

I have a son here, living here. And he's very devoted to me. He'd do anything for me, but there's a difference between your son's wife than it is with your own daughter. And Gerri is a very fine, sweet Christian woman...it's not that. But I think you're much happier in your own daughter's home.

A few participants felt that anyone and everyone in the family could be or become suited to provide assistance. A granddaughter said:

It needs to be a group effort. I don't think any one person needs to do it. And that's part of the reason for being a family...

Several respondents had difficulty answering this question. Although they maintained that either gender was suited, they equivocated while answering the question. A daughter said:

No, I think...I mean...if you are looking for men or women, I'm not going to say that because I don't think...I think men are just as good, or should be, or should have as much responsibility. Maybe women are more suited.

Another woman who was helping her mother-in-law answered by saying:

If it's a man, I think the male will probably take care of the father, but I have now...it's wrong too, because I had a brother...he died with cirrhosis of the liver,

and I had to take care of him...I mean I had to do everything for him, so it could

be either one to me.

It was evident that respondents were open to the idea that either men or women could be

capable caregivers, but some found that their experience simply did not match their

thoughts about this issue. In their discourse, they grappled with this discrepancy.

Personality characteristics. In addition to gender, respondents named several

personality characteristics that indicated that the person was well-suited to caregiving.

Two characteristics emerged from the discourse: caring and patient.

Nearly half of the respondents felt that the ability to give and to be compassionate

was paramount in caring for an older relative. A father whose daughter was primary

caregiver to his in-laws said of her:

Then Sheila has always been, I think she is a lot like her mother and I, we are

givers or servants or whatever; we feel that way. Anyway, that's what we end up

doing.

The way a caregiving daughter described herself was illustrative:

I have a lot of compassion...and I realize that. Too much almost for my own

good. It can be a weakness, too...

One in three respondents mentioned patience as a personality characteristic

required to care well for an elderly relative or parent. A primary caregiving daughter

disqualified her sister from caregiving with these words:

My sister cannot...and I'll tell you why. She's too high strung. She can't sit still

five minutes. She's a traveler. She has no patience. She snaps off, like that.

This sister had once relieved her while she traveled out of state to see a new grandson,

and had "begged" her to return early.

Several husbands disqualified themselves as primary caregivers while lauding

their wives' efforts: One man said:

I couldn't handle it. Not the way she does. She never gets angry. She

never...says nothing. I don't know how she does it.

A second said:

She has the patience. She has that type of heart; I don't.

Most respondents commented upon both gender and personality characteristics in

answering the question of who they thought was best suited to caring for an older relative.

Summary. The behavior of most respondents in this study fit prevailing cultural

expectations of gender role behavior. However, the thinking of the respondents did not

necessarily match their behavior. Although some respondents designated women as best

suited to be caregivers to elderly family members, others claimed that both men and

women could be well-suited to such caregiving. Some of the latter group included

primary caregivers. Finally, many respondents highlighted the importance of possessing

a caring and/or patient personality in order to be a successful caregiver to an older

relative.

<div align="center">Research Question 4: Shaping a Sense of Responsibility</div>

<div align="center">and Use of Formal Care Services</div>

This question explored two issues: How the feelings and interpersonal ties of family members shaped their sense of responsibility to the older member, and how these relationships affected their use of formal care services. Other factors that contributed to the use of formal services are also reported in this section. The sense of responsibility to the older family member was shaped by both feelings and family ties. Figure 5 illustrates the results of this analysis.

Feelings

Life experiences. The feelings of several respondents were shaped by life experiences. These experiences were professional, volunteer, or special in nature. Among the study participants were a psychologist who had worked with developmentally disabled children, a pastor, an ombudsman, a medical technologist, and a primary caregiver who had formerly done some sitting with elderly homebound persons as a second job. Each of them had formed their ideas about responsibility to their care recipients based in part upon their work experiences. The medical technologist noted the importance of family care in conjunction with hospital care of the elderly:
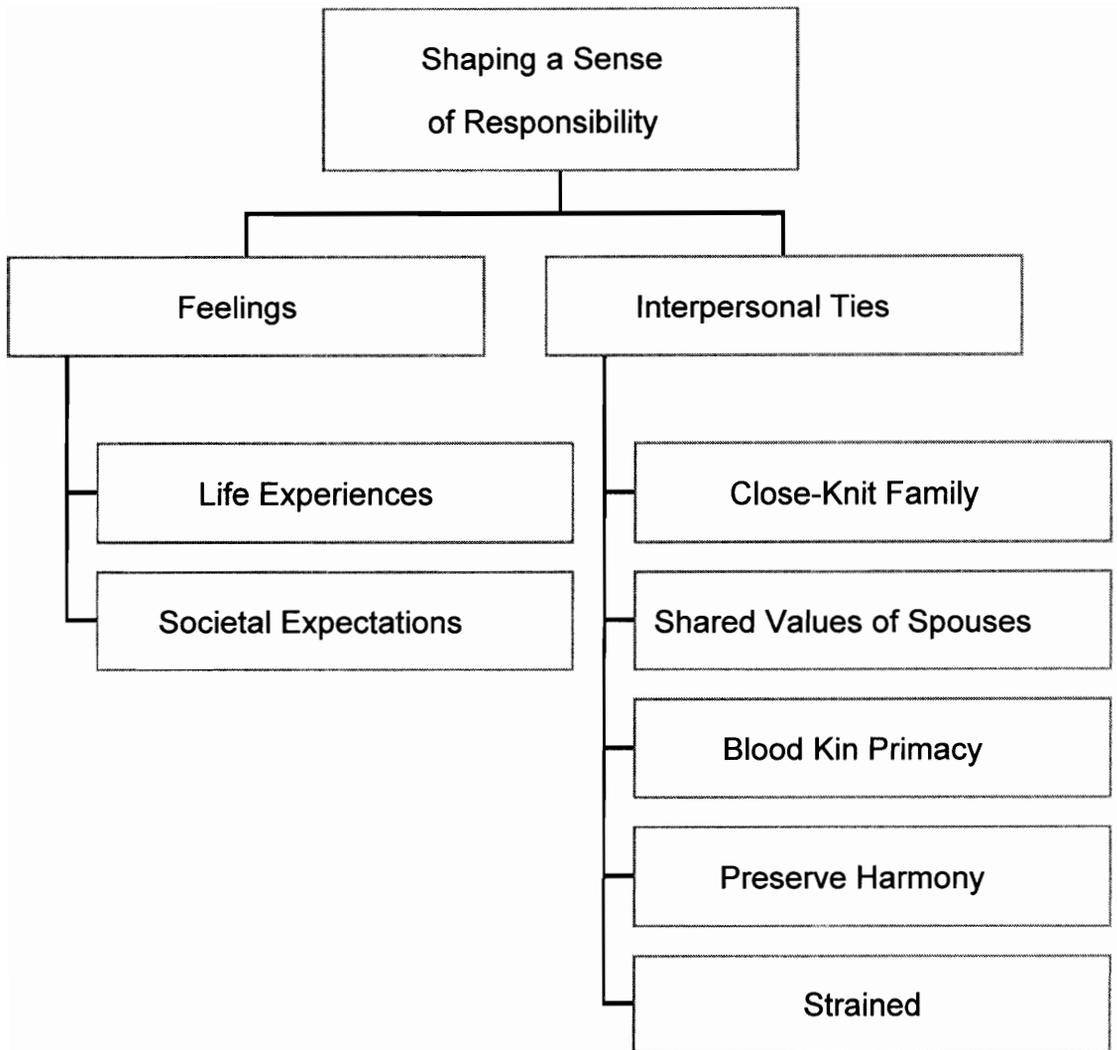
Figure 5. Shaping a Sense of Responsibility

Going into the rooms I see a lot of people, especially older people, that are just, I mean the family thinks that the hospital's gonna provide every need and it just doesn't happen....But...you can't expect an institution to provide that part of life that a family provides. They can provide the meals...and the bed and the medical...but they can't give you the "Rocky" talks to make you eat when you don't feel like eating...and just the love and the thing that makes you want to go on as opposed to just sitting there...

On the basis of her work experiences and her family's care of her grandmother, this young woman was wary of using formal care services, and said she would do as much as possible herself when it was time to care for her parents.

Two additional respondents had volunteer experience working with the elderly and with children that had contributed to the development of their sense of responsibility to older family members. Both were very attentive to their mothers; one as primary caregiver; the other as secondary, but he visited his mother daily.

The special experience mentioned by four participants was the Great Depression. Each of them talked about how this seminal event had affected their families by bringing them closer together and making them reliant upon each other for physical and emotional support. Several respondents noted that their parents had lived quite frugally because of the Depression, and were able to support themselves financially in their later years.

Societal expectations. In addition to these life experiences, respondents had strong feelings about society's treatment of elderly people. When queried about whether

or not society had influenced their sense of responsibility to their older family members, most participants replied with an emphatic no! Their responses fit within one of two categories: indifference to society's views or opposition to society's views about caring for elderly relatives.

One fourth of the respondents felt that societal views had no impact upon their ideas about how to care for their loved ones. Typical of this group's responses was the following:

Basically I would say that what society thinks, or what have you, is not that much a concern to me...and I feel comfortable with what I do...and don't really worry that much about what society...thinks that I should do.

More than half of the respondents saw their views of the appropriateness of parent/grandparent care at home as the opposite of what society currently promotes. Several persons recalled their discussions with friends and acquaintances who saw them as crazy for taking their relatives into their homes. A woman caring for her mother-in-law related the following:

I'm becoming aware that societal attitudes are not the same as ours. Last week I got into a discussion with my friend's sister, who's, she lives in Washington, and...she kind of looked at me as if we were strange. She said, "Oh, I know a lot of people whose parents are old, but they don't take them into their house!" It was like, "You are weird, what are you doing?" She was too polite to say "you're weird," but that's what she was thinking.

Other respondents described societal views of the elderly as quite harsh: most persons in society throw old people away, dump them in institutions, and refuse to help them when they need it. A third group felt that most members of society were too self-centered to care about their older members, and that societal influence, in general, was a bad influence. A son-in-law spoke the following words:

> In my perception, the societal view is one that, not only is there nothing wrong with that [institutionalizing elders], but that is really...I don't think that the general view that I perceive, which may or may not be accurate, is one to or for any great responsibility.

Grandchildren were just as vocal as their parents about negative societal views of the elderly. A 23-year-old grandson painted a bleak, though colorful, picture of society's outlook on older people:

> I think, in this day and age, it's sort of like an elderly person is...it's just like there is some disease or they are like a fungus or some...so...as a whole, America has just a foul outlook on the elderly, and it's just like this extra baggage...everybody looks at them as extra baggage....And I do not feel that way.

Not one respondent had a positive comment about society's view of its older members, and few found much support from society for home care of their relatives. Thus, respondents in this study seemed to shape their sense of responsibility without influence from society, or in reaction to the perceived influence of contemporary society.

<u>Interpersonal Ties</u>

Relations among family members had great importance in the shaping of a sense of responsibility to older family members. There were five distinct areas of family relations that were highlighted by family members. They included a close-knit family, shared values between spouses regarding eldercare, the primacy of blood kin relations, efforts to preserve harmony in relationships, and strained family relations. Each of these categories is discussed in turn.

<u>Close relationships</u>. Nine families mentioned closeness in family relations when describing their feelings of filial responsibility during their interviews. Six of the nine families were represented by the discourse of each family member interviewed. Three of these multigenerational families lived in close proximity to each other; two on adjacent properties and one in the same home. In five of the remaining six families, all or most members lived in the same town. Closeness of family members was seen as a vital part of interpersonal ties. Describing his family, a grandson said:

> The core of our family is really rooted in two things: love and trust. There's a lot
> of love that is shared cross-generational and a lot of trust...

His uncle agreed:

> ...so, we have a real closeness, and our core values are pretty well identical. I don't
> think you'll find any difference at all.

His daughter's response was:

...as a family, I feel like we are very close and very fortunate, and it never even occurred to me that a family member wouldn't take care of another family member if the situation was needed.

Statements like hers were repeated by members of many respondent families.

Another type of closeness in intergenerational relations was with the person now receiving care. Half of the study respondents cited this relationship as influencing their feelings of responsibility towards the older relative. Of special interest is the fact that the respondents who highlighted this relationship were predominantly grandchildren and in-laws; responses of sons and daughters comprised a minority of the participants in this category. Many described the flow of assistance that occurred from the older relative to them in times past. A daughter-in-law's words represented respondents' experiences:

...she would help me when I was young, and didn't have all the wisdom she had. She would keep the kids-not that I ever put them off on her-but when I needed to go to the store or had a doctor's appointment, she spent a lot of quality time with them. And when she made a pie, she had a pan, big as a pizza pan, it was big enough for three families. And we'd all have pie. She's just been such a lovin' mother-in-law. I love her like a mother.

Several grandchildren received financial assistance from their grandparents during their childhood. Others talked about their memories of family gatherings spearheaded by the care recipient. One granddaughter saw her grandmother as a role model:

She is just someone that you love and respect and she was such a wonderful role model for me as a child. I mean she is probably...one of the best people that you've ever....If I could be one-tenth of the person that she was, I would be pleased with life. So, there has never been any question that you want her taken care of and want to do for her.

A care recipient who was interviewed for this study summed up these reflections best when she told me:

You reap what you sow.

Shared values. Another important area of family relations that emerged from the data was that of shared values between spouses. These couples' values were alike with regard to caring for older family members at home. All but one couple interviewed was represented in this category; 12 of the 15 families in the study were included. Whether interviewed separately or together, spouses repeated each other's words. A wife said:

...my husband and I both feel really strongly that you should care for an older person in the home. That is, mother, father.

In a separate interview, her husband agreed:

Joan feels the way I do....We're working together in this area.

A few couples noted that similarity in religious backgrounds contributed to their shared values. A wife observed:

My family and my husband's family were a lot alike in their religion, in their teachings. So it's just like; it's a combined thing.

Sharing values of home care for elderly parents eased decision-making and provided a continual basis of mutual support for the caregiving couple.

Blood kin primacy. A third general area of interpersonal ties focused upon the belief that the persons who were related by blood to care recipients should take the lead in making decisions related to their care. This issue was mentioned by a quarter of the respondents representing eight of the families. Several of the in-laws who responded to this category felt that they would be interfering in family affairs if they intervened: phrases such as "it's not my place" and "ethical reasons" were stated to make this point. Even when the primary caregiver was an in-law, the blood relatives often had the power to make the decisions regarding the older family members. The following observation was made by a granddaughter whose mother served as primary caregiver:

> I think that it goes to the sons...mom can do everything in the world that she wants to and express every opinion that she feels and I can too, but basically it boils down to Dad and Tom and how they feel...but I definitely think that it would fall to them, the final decisions.

The general rule appeared to be that in-laws could carry out daily tasks and give input, but blood kin made the final decisions.

Harmony. Efforts to preserve harmony in families caring for older parents were noted by 11 respondents who were members of eight families in the study. Caregiving decisions that affected extended family were among those made to preserve harmony. A

son who had moved his mother in with him recently did so after his aunt and uncle, who lived across the street from her, indicated that they could no longer look after her:

> I think part of what has sort of created the timing here has been a very clear signal from them that they were no longer able to do the things, to meet the demands that having mom living across the street from them meant to them.

His decision was a difficult one; his mother left the town and state in which she had spent most of her life, and was having difficulty accepting that she must live with her son, but he felt it was a superior move to placing her in a nursing home in her home town.

Several married respondents talked about keeping the peace between each other. A daughter who moved her stroke-impaired mother out of a nursing home and into her home related her husband's response:

> He said, "You would have made life miserable for me, so I said you could do it [bring your mother home]." I don't like to think of myself making life miserable for him, but maybe I would have. I wouldn't have been happy, so he wouldn't have been happy...

Two sisters who were sharing responsibilities for their mother by alternating blocks of time each of them spent in the role of primary caregiver had recently renegotiated the length of that block of time. The sister who preferred the prior arrangement said:

> If she can handle that, then we'll stay with that. I think that'll give us a long enough time to do a little vacation or whatever.

Strained relationships. Although conflicted family relations were not common among the majority of families in this study, there were some situations that contributed to strained relationships. Eight respondents in six families discussed a problem in family relationships. Refusal to take any responsibility for the aged parent or perceptions of unequal distribution of caregiving labor were the two areas of complaint among respondents. In only two of the study families, however, did the vast majority of the responsibility for providing assistance fall to one person.

Summary. A sense of responsibility was shaped by respondent's feelings and interpersonal family ties. A small percentage of respondents had noteworthy life experiences that had shaped their feelings of responsibility. None of the respondents felt that society had shaped their feelings of responsibility; most attributed their sense of responsibility to their family relationships. Among the aspects of family relations deemed important by respondents were closeness among family members and to the care recipient, spousal sharing of values about caring for older family members at home, and the primacy of blood kin in making caregiving decisions. Preserving family harmony and strained relations were minor contributors to family relations in caring for older members.

Service Use

Of the 15 families in this study, 11 were currently using some person or agency to assist their caregiving efforts. Two of the four families not using formal services had used them in the past. Thus, most of the families had experience with formal care providers, and contributed reasons for their use.

Families tended to employ home health care, home delivered meals, or sitter-companions for their older members. Sitter-companions, sometimes referred to as home care workers or personal care aides, performed labor-intensive personal care to elderly persons. They also took them on outings, to the doctor, or stayed with them overnight to provide protection and assistance as necessary. A few performed light housekeeping chores. Seven families routinely employed one or more home care workers for their parents. Only one of those families received this service through a state-funded program. Most families obtained their workers through word of mouth referrals, and used private funds to pay for them.

There were six factors that shaped patterns of service utilization among families in this study. Three of them were related to family relationships; they included care recipient wishes, behavior, and needs; caregiver limitations, independence, trust of providers, and positive experiences with providers, and marital/personal fulfillment. These factors are discussed first. The remaining factors were financial resources, perceived utility of services, and employment. A pictorial depiction of these factors is found in Figure 6.

Care recipient factors. Care recipients had varied reactions to the use of formal care services, ranging from resisting them to demanding them. Resisting services was motivated by the wish to maintain independence or to avoid meeting new people.
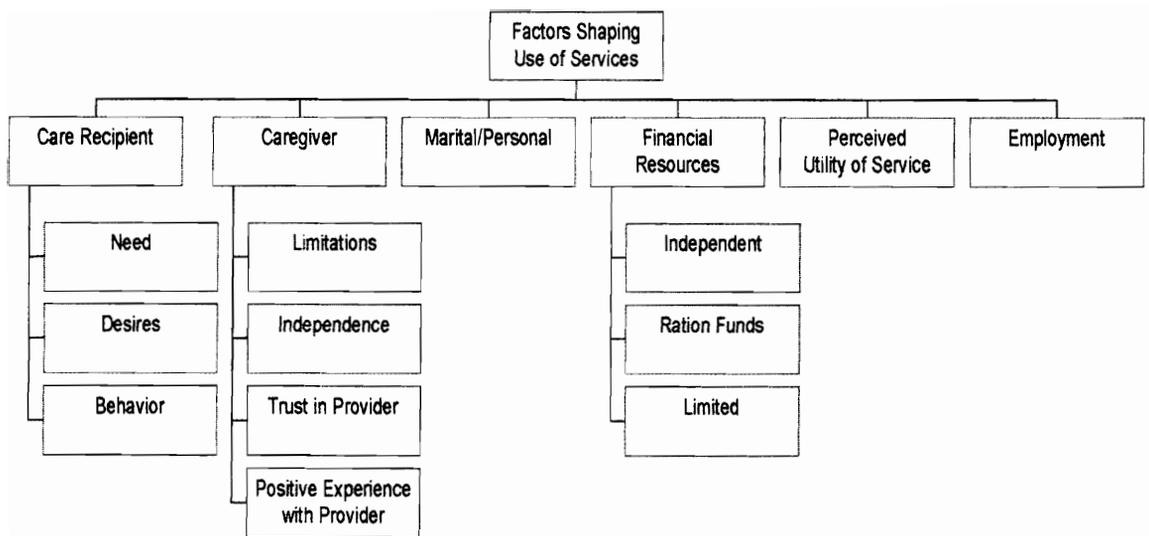
Figure 6. Factors Shaping Use of Services

Demanding services was prompted by the desire of the person receiving care to have someone other than family tending to personal care needs.

Comments about the impact of the behavior of care recipients emphasized the same themes as their wishes for service use. Several caregivers noted that their parents refused to consider using formal services in an effort to maintain autonomy. Other caregivers talked about parental passivity and dependence upon them to make decisions about service use. Demanding and passive behaviors seemed to garner the most attention for care recipients, and in most cases, considerable resentment from their caregivers.

Far more prevalent than discourse about care recipient wishes or behavior, however, was discourse that connected the use of services with the actual needs of the older family member. Half of all respondents representing nearly all families cited need as an important reason for use of formal services. When asked if their beliefs had affected their use of services, most respondents said no; that the needs of the older person prompted the acquisition of formal services. A granddaughter remarked:

> I don't think it would be so much beliefs that would determine what we did as much as it would be what are the physical needs, and then after the physical needs were taken care of, then we would go with how I felt about it.

A son-in-law summed up respondent feelings by saying:

> ...if the need is there, and you believe that the need is there, as far as kind of care that the individual needs, you work out whatever you need to work out to provide it.

Caregiver factors. In addition to care recipient factors, there were four caregiver factors that shaped the use of formal care services. They included physical and emotional limitations, independence, trust in formal care providers, and positive experiences, past or present, with service providers. Each of these factors is discussed in turn.

Five respondents stated that emotional factors had prompted their use of formal services. All had parents who needed assistance with several activities of daily living, and all had been caring for their relatives for over a year. Several had responsibility for more than one relative. Depression, stress, and burnout were the emotions that led to a search for assistance. A daughter who has cared for her mother since 1986 described her decision to find help:

> I had reached the point where I didn't feel like she was getting adequate care from me. I felt like bringing somebody in; that they would be able to give her a better bath....and especially when I got to the point where burnout was the problem. I felt like my mother was better off in somebody else's hands than mine.

A couple of respondents had physical problems that limited what they could do for their relatives. One woman's Carpal Tunnel Syndrome and surgeries rendered her unable to assist her mother-in-law with housekeeping chores, so help was obtained through a special program for low-income elderly.

A few caregivers in this study felt they could or should do without outside help for as long as possible. Most of these persons saw it as their responsibility to provide the

help to older family members, or felt that they would do a better job than hired service providers.

More common among respondents were issues of trust in formal care providers. Mentioned by eight families who were currently receiving services, the ability to trust the provider with the older person and in the home was important to the decision to use services. A primary caregiver expressed her feelings:

> I'm so attached to her that I have a hard time trusting people....I have sat and I've needed help sometimes so much but I sat there with the phone book opened, and callin' all these agencies and ask them 5,000 questions and there's still no way I would ever have one of them come in. I just have to know that it's someone who is safe...that I could trust her with a problem....I have to know that it's A-OK before I'm going to let them come into my home and take care of Gloria.

This caregiver ultimately found two home care workers that she was comfortable with, but they were referred by friends or other caregivers, and did not work for agencies. Avoidance of agency-based help was common among families in this study.

Positive experiences with formal care providers was noted by seven families who were using home care workers routinely. This type of experience built trust and gave family caregivers a sense of security. Phrases such as "they love her [care recipient]," "they are patient with her," and "[they] are very affectionate towards her" were repeated by caregivers who were satisfied with their hired workers. Formal training of home care workers was less important to family caregivers than a positive relationship with the older

parent, suggesting that what families want in their absence is someone who can provide care with the same concern and compassion they exhibit.

Marital and personal issues. Additional relationship factors that prompted use of formal services were desires for marital and personal fulfillment. The need for time and energy to give oneself or one's marriage prompted 15 respondents to use hired assistance. Several respondents felt that they couldn't spend 100% of their time providing care and do a good job of it. Of her decision to use help, a woman said:

> I know that I could not do it all myself. I know this, that I would lose patience, and I would be overwhelmed, and I would be irritable with her; so that it hasn't been at all difficult to...call a sitter.

Other respondents felt that their marriages were the primary relationships in their lives, and that respite from caregiving was needed to give attention to their spouses. One woman who was caring for both her parents until recently recalled how her respite came about:

> George would see that I needed this. I wouldn't even see it. But when I got away, wow, you would look back, and you would think, I'm not paying any attention to my husband, like he's not even there. And then you would see how tired you were, physically...mentally, and you wouldn't want to go back.

Her husband stated his views directly:

> This relationship [marital] is primary. It has to be around when he's gone. That's the number one. We have to take care of that more than anything else.

In summary, aspects of several family relationships contributed to the use or non-use of formal services. Both care recipient and caregiver traits were important to decisions about service use. A desire to attend to self or marital relationships prompted service use. But most important was the actual need of the care recipient for formal services. Families in this study found outside help when their parents' situations warranted such help. The next section of this paper discusses additional factors that shaped use of formal care services.

Financial resources. The family's financial resources played a very important role in decision-making about service use. Whenever possible, the care recipient's financial resources were used to pay for outside help. In most of this study's families, that was not a problem for the family. Discourse about the impact of financial resources reflected three themes: independence, rationing of funds, and financial problems.

Seven families claimed that their older parents were financially independent, and were able to pay for whatever formal care they needed. Two families were using sitters on a 24 hour basis. The care recipients in these families were wealthy. Money was not limited for them or their families. The remainder of the families in this category noted that their parents had saved money for their old age, and could pay for whatever service was needed now or in the future. A granddaughter knew her grandparent's situation well:

I know that my mother...my grandmother has given her...a certificate of [deposit]...what she started for my mother years ago. In the event of her death, it would be hers [mother's]. My mother has it nicely tucked away because she

knows in the event of a major catastrophe where she had an aneurysm or a stroke or was totally disabled, that her insurance may not pay for all that. So she has that tucked away, just in case something like that happens...

Six families had parents with adequate, but not unlimited, financial resources. They talked about the need to use funds wisely; to obtain services when needed, but hold some assets in reserve. A man described his impressions of his grandmother's situation in this way:

The money is there, but at the same time, you don't want to spend it all 'cause you gotta be prepared for what might could happen later on in the future....We don't know what the future is going to bring.

In some families, there were two older parents whose needs required consideration. A daughter caring for her mother and father wanted to bring in more outside help, but also felt the pressure of her father's desire to conserve money:

I know that he doesn't want to waste a penny. And he keeps saying, "Well, what if one of us has to go to the hospital, we may need money for that. If she [spouse] has to go to a nursing home, we may need money for that." So he still feels like there may be something down the road that we would need it worse and so, I don't feel free to go in and [say], well, I'm just going to have somebody come in every day and it's going to cost you so much and that's just the way it is.

Another way of coping with limited funds was to hire inexpensive help. Students from a local fundamentalist college were hired by several families as sitters, or to provide respite care.

Two families had financial difficulties stemming from limited parental income. Both were supplementing their parent's needs with their own monies, but were concerned about the future. A divorced woman who worked full-time helped her mother with basic household and medication expenses. Two sisters cared for their mother who had Alzheimer's Disease. They obtained needed respite by using a sitter, but worried that they might have to let her go because of limited funds. One of them said:

> But now, if we have to take it out of our pockets...if we have to continue to do this
> on a long-term basis, it will just end up being I'll care for her during my time, and
> if I can afford a day or two, I'll pay for it. Otherwise, I'll have to do it and...that's
> what she'll [sister] have to do.

Perceived utility. A fifth factor that shaped use of care providers was the perceived utility of the service. Nine families commented that the usefulness of a service encouraged or discouraged them from using that service. Utility of a service was frequently defined as its convenience to both care recipient and caregiver. A primary caregiver commented on the convenience of having home health nursing services come to her mother's home:

And also taking the blood, so we didn't have to get her...it's a real chore now to get mother into a car and out of the car once you get where you're going. It takes a long time...because she is so slow...you have to leave early.

On the other hand, some caregivers noted the strain of working with care provider's schedules, and orienting them to the home and needs of the care recipient. A caregiver whose father received baths from a local agency worker stated:

The difficulty is, you are at their beck and call, and they don't always tell you when they are coming. So, if you wanted to dart out to the grocery store, you couldn't always do that. You had to be there, and that was a real obstacle, and still is in some respects. It is straining to keep telling the same thing over and over. Not only where things are in your home, but how your parents react to this, and just even training people is hard.

Other caregivers felt that services were provided in an fragmented fashion, and wanted a system of providers that could stay with the parent for more than just one hour at a time. Several persons using home care workers valued the ones who were flexible about time, so that if they were late arriving home, they did not have to worry about their parent being left alone.

The general message that emerged from family discourse about services was that services were useful if they were available and affordable, and service providers flexible and trustworthy. If those conditions were met, participants had no reluctance to use them.

In the concluding remarks of their interviews, many of them recommended that others faced with similar circumstances seek the assistance of formal care providers.

Employment. The final factor that shaped the use of formal care providers was employment of primary and occasionally, secondary caregivers. However, in this study, employment was a minor issue in most families. In all but two families, there was at least one person available to provide assistance during the daytime. Families in the study with caregivers employed full-time had parents who needed assistance with only instrumental activities of daily living. Caregiver employment had prompted use of housekeeping services and sitter services on a short-term basis.

<div align="center">

Research Question 5: The Effect of Service Use

on Perceptions of Responsibility to the Parent

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Primary and secondary caregivers who had ever used formal care services were asked whether or not the use of these services had affected perceptions of their responsibilities for assisting their parents. Thirty-one respondents offered answers that covered five categories: they felt no less responsible, they felt relieved of continuous responsibility, they felt an increased sense of responsibility, they felt that they had improved their caregiving, and formal care providers affirmed their caregiving efforts. A diagram of these categories is contained in Figure 7.
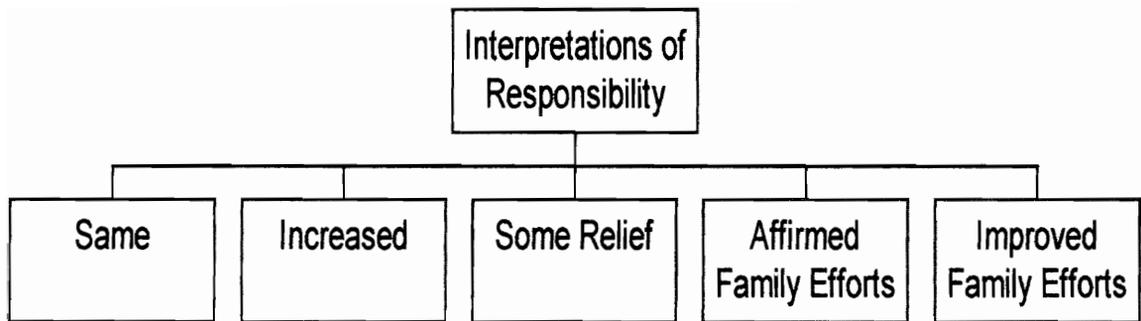
Figure 7. Interpretations of Responsibility with Use of Services

Responsibility Unchanged

Half of all respondents felt the same degree of responsibility with service use as they did before its use. The statement of a primary caregiving daughter represented the feelings of this group. She said:

> I'm going to feel responsible for her, no matter who's around saying anything, you know, one way or the other.

A son-in-law who was secondary caregiver to both his mother and mother-in-law reinforced this by saying:

> The basic responsibility for care still falls with a family member.

The message of this group was clear: formal care services help, but they retained responsibility for their parents' care.

Relief from Continuous Caregiving

Nine respondents stated that the use of outside help relieved the family of responsibility for providing continuous care themselves. Their answers ranged from a sense of short-term relief from worry about the parent's safety to the relief expressed by a primary caregiver who handled responsibility differently than others:

> I'm afraid I probably, if it's somebody good, I kind of dish it all out to them. Let them do it all....But then I have mother off hours. They give me a break. Then I do what I want to do.

A granddaughter noted that the use of sitter services freed up family members to meet the emotional needs of the care recipient.

Increased Responsibility

Three respondents, all primary caregivers, perceived a heightened sense of responsibility as the result of using formal services. One of these caregivers had sitters in her home 24 hours a day; the other two were very conscientious caregivers who wanted to do everything right. One of them remarked:

> Well, there is a burden placed on you that now you know what to do, but you can't get to it. I had to learn and tell myself, well every single person here is an expert in his field, and not only that, but he believes his field is the best and the most important.

Improved Efforts

When asked about their perceptions of their responsibilities to their parents, nine respondents noted that using formal services had actually improved their caregiving efforts. Care providers, both professional and para-professional, had taught families techniques and made suggestions for equipment that assisted in making family care work easier. One primary caregiver wryly observed:

> I feel equipped to go into the business myself.

Affirmed Efforts

Finally, three respondents felt that using service providers affirmed the importance of family care. A primary caregiving daughter who was not currently using services said:

I think it helped. I don't know if it inspired you or what, but you do get a good feeling from it. You feel that you can see the importance, you know what you're doing is fairly important, when you see someone else do it.

The majority of respondents in this study perceived themselves, the family caregivers, as responsible for their parents regardless of how much outside help was used. However, most of them valued the assistance of care providers, either as those who provided relief from constant caregiving, or as persons who improved and affirmed family caregiving efforts.

Summary of Findings

There were many interesting findings in this study. Chief among them were the ways in which family members defined the meaning of responsibility to their parents, in-laws, or grandparents as a consideration of both the older persons' needs and the needs of the family as a whole. The pervasiveness of this definition was illustrated in the findings about factors affecting use of formal services; families felt the needs of the older member were foremost in their decisions to use services, but they were clearly influenced by the needs of other family members. Both caregiver and spousal needs were important when deciding upon the use of formal services.

Learning filial responsibility was described as a life-long process of incorporating the expectations of parents and other family members, observing family and friends care for elderly parents, and enacting and refining roles as caring and responsive children and grandchildren. The participants in this study appeared to have learned behavior patterns

that are culturally approved for men and women in American society, but many of them felt that either men or women could do a good job of providing assistance to elderly parents. When it came to assisting with personal care tasks such as bathing and toileting, however, most respondents felt that cross-gender assistance was inappropriate.

The sense of responsibility expressed by respondents in this study was shaped, in part, by feelings developed over the life course. Such feelings often stemmed from experiences with caring for others, or from marker events such as the Great Depression. More prevalent in shaping a sense of responsibility were family ties. A close-knit family, similar values among couples regarding filial responsibilities, and desires to preserve harmony among family members contributed to a sense of responsibility towards older members who needed assistance. Family ties that were conflictual or strained led to a heightened sense of responsibility for the member or members who were willing to assume responsibility for helping the parent.

Finally, using formal services did not change perceptions of responsibility among respondents in this study; they perceived the overall or primary responsibility for their parents as theirs regardless of how much work was done by paid help. The next chapter offers interpretations of key findings and a revised conceptual framework for service use and family caregiving in light of the results of this study.

Chapter V: Discussion

Overview

The purpose of this study is to describe how families who care for elderly parents at home develop a sense of responsibility to their parents, how members of the multigenerational family fashion their caregiving roles, and how performance of these roles and sense of responsibility are affected by the use of formal care services. Findings underscore the complex nature of family caregiving. Caregiving patterns vary with the particular needs of the older persons and relationships among family members.

This chapter begins with a review and discussion of the significant findings of the study. These are followed by a consideration of how the study results might contribute to development of theory in family caregiving. The study's limitations are then reviewed. Implications of the research findings for long-term care policy and practice are examined, and recommendations for future research are offered.

Significant Findings

Several significant findings emerged from this study. These results are discussed in terms of the research questions, beginning with the meaning of responsibility.

Meaning of Responsibility

Three findings are of special importance because of their implications for the scope of home care by children and grandchildren. First is the finding that filial responsibility means much more than assisting a parent with tasks of daily living; it means demonstrating sensitivity to parental safety, comfort, autonomy, and emotional

needs, as well as providing companionship to the older parent. This finding adds to the growing body of research that emphasizes a broader definition of filial responsibility than performance of hands-on caregiving tasks (Blieszner & Hamon, 1992). In a recent review of caregiving literature by Walker, Pratt, and Eddy (1995), this type of assistance was labeled socioemotional aid. The authors stressed that the failure to consider socioemotional aid in caregiving research "decontextualizes caregiving" (p. 404), and may produce incomplete or inaccurate results in studies of caregiving outcomes.

Because so few investigators have examined the role of the multigenerational family in caregiving, the finding that the needs of the entire family are taken into account when establishing the meaning of caregiving to the older member is crucial to understanding how families carry out their responsibilities. For married caregivers in this study, preservation of the marital bond was linked to placing limits on parental caregiving at home, obtaining respite care, and performing one's caregiving role.

Finally, the finding that respondents in this study shared caregiving responsibilities with other family members replicates an earlier study's finding that an average of three family members were "substantially involved" in the total caregiving activities (Mellins, Blum, Boyd-Davis, & Gatz, 1993). These results affirm the importance of studies of family caregiving that tap the input of multiple family members. By studying the family network, researchers can learn more about the various roles of family members, as well as relationship issues that contribute to the formation and maintenance of the total caregiving picture.

Learning Responsibility

Consistent with a symbolic interactionist viewpoint, respondents reported that interaction with several family members throughout their lives had substantial impact upon the manner in which they conceptualized and carried out their caregiving to parents, grandparents, and in-laws. Observation of or participation in the daily lives of older relatives during childhood had a powerful impact upon current caregiving behavior for most respondents in this study. In the simple stories they told, respondents described a tradition of interacting with and providing assistance to older relatives in various stages of dependency. These stories provided a context for development of intergenerational responsibility that helps to explain why families choose to keep their aging parents at home, despite the sacrifices often engendered by such decisions. These results are also consistent with Rossi and Rossi's (1990) finding that early family experiences were among the family characteristics that predicted differences in feelings of obligation to assist family members.

The Gendered Division of Labor

The results of this research provided support for the socialist-feminist explanation of women's dominance as caregivers to the elderly. When asked who was best suited to caregiving, half of all respondents named women, citing their inherent nature or the cultural expectations for women in American society. This finding validates Acker's (1989) notion of gender as structured and symbolic differences between men and women. Consistent with Aronson's (1992) findings, some female respondents excused their

husbands or brothers from most caregiving responsibilities, particularly personal care tasks to their mothers or mothers-in-law.

According to Calasanti and Zajicek (1993), "Socialist feminists emphasize the reproduction of social relations in a broad sense, including...such things as socialization and education of children, and the reproduction and maintenance of labor power" (p.123). Among the majority of families in this study who practiced a traditional breadwinner-homemaker division of labor, gender ideology tended to be traditional, and the youngest generation (grandchildren) were reproducing a gendered behavior pattern in their behaviors towards their grandparents. For the most part, granddaughters were involved in the caregiving process: they relieved their mothers of caregiving responsibilities when asked to do so, and/or provided social support to their parents and grandparents. On the other hand, many grandsons were peripherally involved or uninvolved with their grandparents. The nature of their contact ranged from repairing a failed air conditioning system to visiting the grandparent on occasion. When asked how her three male cousins would answer the question of who is best suited to provide help to their parents, a granddaughter replied:

> ...oh, I know the boys would definitely assume that a female was going to take
> care of them [the boys' parents], I can tell you that right now. I'm not sure that I
> can tell you which one [wife] they would pick, but it would definitely be a female.

One of her two male cousins interviewed for this study made the following observation about male and female behavior patterns in his family:

I honestly think ...women are more perceptive of this [family member's need for help] than guys are. I don't know why. But in our family I think that's definitely true. Most of the women don't work for one thing; in fact, none of them work, so they're closer to the core family thing.

In this family, as in others, the perceptiveness of female family members is linked with their availability due to their absence from the paid labor force. The female cousin's observation suggests that caring for the elderly parents of her male cousins will be expected of their wives; thereby reproducing the power differentials between men and women. Men can choose the nature and limits of their care to older parents, whereas women do not have or feel that they have such choices.

Another example of how male privilege in choice of caregiving tasks is maintained is illustrated in the respondent's discourse about personal care tasks. Most male respondents insisted that they could not assist their mothers because either they (respondents) were too uncomfortable doing so, or their mothers would view their assistance as an invasion of privacy. Many of the female respondents agreed, and excused the men in their families from performing personal care tasks. However, it was acceptable for women to perform these tasks for men, even if the women were uncomfortable doing so. Several respondents suggested that it would be best for men to care for men, and women for women, but women were not excused from these caregiving duties if no male were available or willing to perform such tasks. The woman who cared for her brother who was dying from cirrhosis of the liver was a good example of the

differing standards for women and men. With only one exception, men in this study had a choice of whether or not to assist with personal care tasks for their female relatives, whereas women did not enjoy such an option. Most grandchildren affirmed these gendered behavior patterns in their interviews, adding to the likelihood that they would reproduce these behaviors when they were called upon to care for their parents in the future..

As previously stated, all but one family in this study practiced a traditional division of labor in the home. All but one of the married women who were primary caregivers were full-time homemakers. They viewed parent care as part of their responsibilities, and breadwinning as part of their spouses' responsibilities, consistent with capitalist ideology, which separates the workplace from the homeplace, and places greater worth on wage labor than home labor. It was interesting to note that it took the efforts of formal care providers--paid laborers--to affirm the value of caregiving labor to three primary caregivers in this study.

Half of the respondents in this study felt that either gender was suited to caregiving, or that personality traits were most important to effective care provision. However, the personality traits they identified as critical for good caregiving were those typically associated with feminine behavior in our society: being caring, compassionate, and patient. Some male respondents differentiated themselves from their wives by claiming that their own personalities were poorly suited to caregiving, whereas their

wives' personalities were well-suited to this labor. This is one way in which the ideology that kinkeeping is women's work is maintained in society.

What might account for the diversity of answers given to the question of who is best suited to caregiving in light of the fact that respondents behaved predominantly along traditional gender lines? One explanation may lie in the way that questions asked in this study were interpreted by respondents. The question "who is best suited to provide help with the various tasks of caregiving" was interpreted differently by respondents, with many of them giving a global answer, thereby failing to apply it to their own personal or family situation. Others did not interpret it as a gender question; instead, they focused upon personality characteristics when answering the question. Thus, the wording of the question was probably too vague to communicate my intended focus effectively.

I dealt with this issue by asking a follow-up question about the respondents' beliefs about whether men or women were better suited to provide care to older family members. Again, I received diverse answers, and some respondents equivocated while answering the question. A few appeared annoyed with me. I wonder how many of these respondents were aware of what they did believe. Possibly their beliefs are less traditional than their behavior. However, the results of this study demonstrate that behaviors such as role modeling and life experiences are far more important than beliefs in shaping the caregiving responsibilities of men and women.

The results of this study did, however, provide insight into how the gendered division of labor was modified in some families, supporting the idea that gender is

socially constructed, rather than inherent and not subject to change. The grandson who cared for his grandmother's personal needs was prompted to do so by the role modeling of his father, who assisted his own mother with her personal care needs, and by the encouragement of his mother, who told him repeatedly, "You'll do what you have to do." In his interview, this young man expressed both his discomfort with performing such tasks and his gradual acceptance of his role as one that was legitimate for all males.

In another family, the primary caregiver gradually helped her spouse defuse the discomfort he felt at helping his mother go to the bathroom by helping him change what it meant for him to do so. She related the process as follows:

Finally, he confessed to me that the problem was that it was very hard for him to see his mother use the bathroom....And I said, "Well, look. It's not just a female thing. She has to use the bathroom. She has to have a diaper now. This is part of our lives. So get over it"....We went along a little further down the road and he had met a fellow here...that is starting to care for his mother...and he said to the man, "You know, it was really hard for me to see my mother go to the bathroom," and he told him, "Now Joe, you're just going to have to get over that." So I thought...we made it!

Symbolic interactionist theorists predict role enactment on the basis of meanings assigned that behavior and role. Therefore, if family members encourage assignment of new or non-stereotypical meanings to certain behavior, the behavior may be more likely to change.

Shaping a Sense of Responsibility and Use of Formal Care Services

Sense of Responsibility. According to the respondents in this study, closeness

among family members makes a significant contribution to developing a sense of

responsibility to an older relative who needs assistance. This finding is consistent with

Rossi and Rossi's (1991) finding that family characteristics such as high levels of

affection and accessibility predicted greater feelings of obligation to kin than those of

families who experience problems such as alcoholism and violence. This study

demonstrated that a part of family closeness included positive, cohesive intergenerational

relationships, such as those between daughters or sons-in-law and older parents, or

between grandchildren and grandparents. This finding illustrates the value of studying

the extended family, as well as the primary caregiver and care recipient, to gain both an

understanding of the nature of assistance given and received, and the transmission of

values such as filial responsibility from one generation to the next.

The opposition to societal expectations expressed by the respondents in this study

was an unexpected finding. Why did the families in this study view their behavior in

opposition to that of society, in light of the evidence that only 5% of all elderly are

institutionalized at any given time? A few respondents reported that their decisions to

keep a parent at home were questioned by friends and acquaintances, but the majority of

respondents generalized society to represent everyone but them. Perhaps a sense of

isolation contributed to their perception of aloneness in their home care efforts. Although

some family caregivers attended support groups, most did not. The extensive labor

performed by many respondents may have precluded socializing with others who have similar values and lifestyles.

A second explanation may lie in the role of media in contemporary society. The media carry few stories about loving home care of elderly family members. News about eldercare is generally focused upon elder abuse and neglect, either at home or in institutional settings. For many persons, such news represents what is happening in society, and presents a stark contrast to their own caregiving efforts. Institutionalizing an older family member is interpreted as throwing them away, possibly subjecting them to abuse and neglect.

A third explanation centers upon the role that politicians play in promoting the idea that families are rapidly disintegrating, and that a only a return to so-called family values will save American society. This idea has played very well with voters in the southeastern region of this country in recent years, as witnessed by the widespread ascendance of the Republican party to power in Southeastern states, accompanied by the flourishing of the so-called religious right. The area from which the sample was drawn is solidly Republican in its recent voting record, and the political preference of the majority of the respondents in this study was Republican. In addition, approximately one-fourth of the study's respondents reported membership in conservative and fundamentalist religious denominations. These groups are likely to believe, at best, that society is a bad influence on its members, and that they are different from society as it currently exists.

Service use. The findings of this study supported prior empirical research and theory development in the area of service utilization patterns. Caregiver limitations, both physical and emotional, contributed to decisions to employ outside help, affirming Bass and Noelker's (1987) finding that the caregivers' as well as the care recipients' needs influence decision-making about formal service use. The findings also suggest the need to study spouse caregivers separately from adult child caregivers when conducting research on service utilization patterns. Using a sample of predominantly spouse caregivers, the factors that Collins and associates (1991) reported as most important in predicting service use, preference for informal care and belief in caregiver independence, were very minor contributors to the factors that affected use of formal services among the adult child caregivers in this study.

Patterns of service utilization among families in this study appear to correspond closely with Montgomery and Kosloski's (1992) conceptual model of factors affecting service use. In their test of the model, they reported that:

> the decision to use services is likely to be made by considering the joint needs of both the dependent elder and the caregiver. As a result, the nature of the caregiving relationship...can be expected to interact with perceptions of need to influence service use (Kosloski & Montgomery, 1994, p. 32)

In this study, perceptions of the parent's need for services in combination with caregiver and care recipient preferences, predicted the use of formal care services.

In interpreting the findings about the factors affecting service use, I noticed an apparent contradiction in what respondents reported. One the one hand, most stated that their beliefs about how to provide care to the older relative had not affected decisions about service use. On the other hand, when asked about factors that influenced them to use or not use services, they cited beliefs in caregiver independence, ability to trust formal care providers, the importance of giving attention to the marital relationship or oneself, and the usefulness of the services provided by those outside the family. Perhaps respondents' interpretations of the two questions (questions 12 and 13, Appendix A) prompted the answers that were given. But what emerges from the data can be linked to the answers they gave to the meaning of responsibility. The families in this study felt that it was important to meet the needs of both the older relative and the whole family. When it was clear that formal services were needed by the older parent, these families worked to obtain them. However, their overall definition of need encompassed the needs of caregivers and other family members for respite and/or time together.

The findings of this study also affirm the fact that economic resources affect the family's ability to hire paid care providers, as well as determine how much assistance can be purchased. A socialist feminist framework can be used to guide the interpretation of service utilization patterns among several of the study's families because of its focus upon the intersection of class and gender when analyzing options that people have for hiring paid caregivers. In two of the families, women were privileged by family wealth, and were able to "buy out of their caregiving responsibilities" (Abel, 1990, p. 150) by

hiring around the clock help. They became care managers, supervising the hands-on labor done by paid providers. They gave their relatives hands-on assistance only when a paid caregiver was late for work or absent because of vacation or a special holiday.

In contrast, men in middle-class families performed caregiving tasks such as cooking, shopping, and transporting their relatives to appointments. They did not enjoy the advantage that the wealthy women had in "buying out" of caregiving. One man who desired respite care so that he and his wife could go out together lamented the high cost of hiring help. He said:

> ...it would be great if there was a situation where we had family here...and the two of us could go somewhere for one weekend. But we don't have that, other than if we hire somebody. I did check into a person who could live in, but it was...she wanted her own room and board, and $15,000 a year. And she would only take care of her--no housework, no cooking...and she had Sundays off.

In his family, the combination of limited economic resources and no available kin meant little respite from caregiving labor for him and his spouse. Thus, class status, as well as gender, affects caregiving responsibilities and lifestyle options.

Emergence of the issue of trust in formal care providers as a factor affecting service use among families in this study affirms the recommendations of Lawton and associates (1989) to study caregiver attitudes towards respite care. Ability to trust nonfamily care providers had a significant impact upon their use. It may also explain the widespread practice in this study of reliance upon friends, family, and fellow support

group members to obtain names of persons who could provide personal care/respite services.

The results of this study also lent some support to the findings of MaloneBeach and colleagues (1992) that frustration and attrition from the formal service system resulted from caregiver lack of control over scheduling and inflexible agency policy. Several primary and secondary caregivers in this study cited inconvenience in matching agency personnel schedules with their own and/or the care recipient's as a reason to discontinue services or change service providers. This situation also contributed to the hiring of persons not connected with agencies who would provide such assistance in a flexible manner.

Of special interest is the use of home care workers (or personal care aides) by half of the families in this study. This kind of service provider has received limited attention from researchers in the field of service utilization. Yet, persons aged 85 and over, especially women, have high utilization rates of various paraprofessional home care workers (Leutz, Capitman, MacAdam, & Abrahams, 1992). In a study of 54 home care workers, their clients and families, Fischer and Eustis (1994) reported that clients were generally satisfied with their care providers, and frequently developed "a measure of affection and attachment" (p. 304) to them. In the present study, fondness between parent and provider was deemed important to family caregiver satisfaction with their paid home care providers, and affirmed their importance in families' abilities to care for their parents at home.

Effect of Service Use on Perceptions of Responsibility

The study findings indicate no significant change in family's perceptions of their responsibility to care for an aged parent when formal services are used. Families continue to embrace responsibility as theirs regardless of the number, frequency, or types of services rendered by paid providers. A possible explanation for this finding comes from a comparison of home care worker responsibilities and family caregiving responsibilities made by Fischer and Eustis (1994). They noted that "the worker role is circumscribed by time, tasks, and arrangement for compensation; the family caregiving role generally has no such framework" (p. 306). These authors point out that the boundaries around family caregiving responsibilities are more diffuse than the boundaries of paid caregiver responsibilities. Because of diffuse boundaries, family caregivers in this study may have perceived themselves as ultimately responsible for whatever care was given to aged relatives, regardless of its source.

Of considerable interest were the assertions of several respondents that the formal care providers had helped them to improve their caregiving efforts. Much of the research literature has tended to focus upon issues of tension and discord between formal and informal caregivers, rather than examining how the use of formal care services may actually contribute to improved family caregiving. In light of the evidence presented in this study, the need for formal services, and for collaboration and cooperation between formal and informal caregivers, is crucial when a family keeps an aged parent at home. Perhaps additional research attention should be focused upon the workings of

collaborative, cooperative arrangements between formal and family caregivers to provide information to gerontologists and service providers about the components of a positive alliance between families and formal providers.

<u>Implications for Theory Development</u>

Two conceptual frameworks that were used to guide the examination of family caregiving patterns can be addressed by the findings of this study. Montgomery and Kosloski's (1992) conceptual model gave direction to the exploration of factors affecting service use, and Brubaker and Brubaker's (1989) model of family caregiving provided a conceptual framework for the study of familial perceptions of responsibility and individual and family ethos. Using a revised version of the Brubaker and Brubaker conceptual framework as a guide, the relationships hypothesized among the variables at the inception of the study appear in Figure 8.

After careful examination of the results of this study, I decided that the best way to conceptualize family care for parents, including service utilization patterns, was to develop separate conceptual frameworks for the issues of service utilization and family caregiving patterns. The findings of this study indicated that perceptions of responsibility and individual and family ethos had <u>little</u> influence upon use of formal care services among families in this study. Instead, the factors proposed in Montgomery and
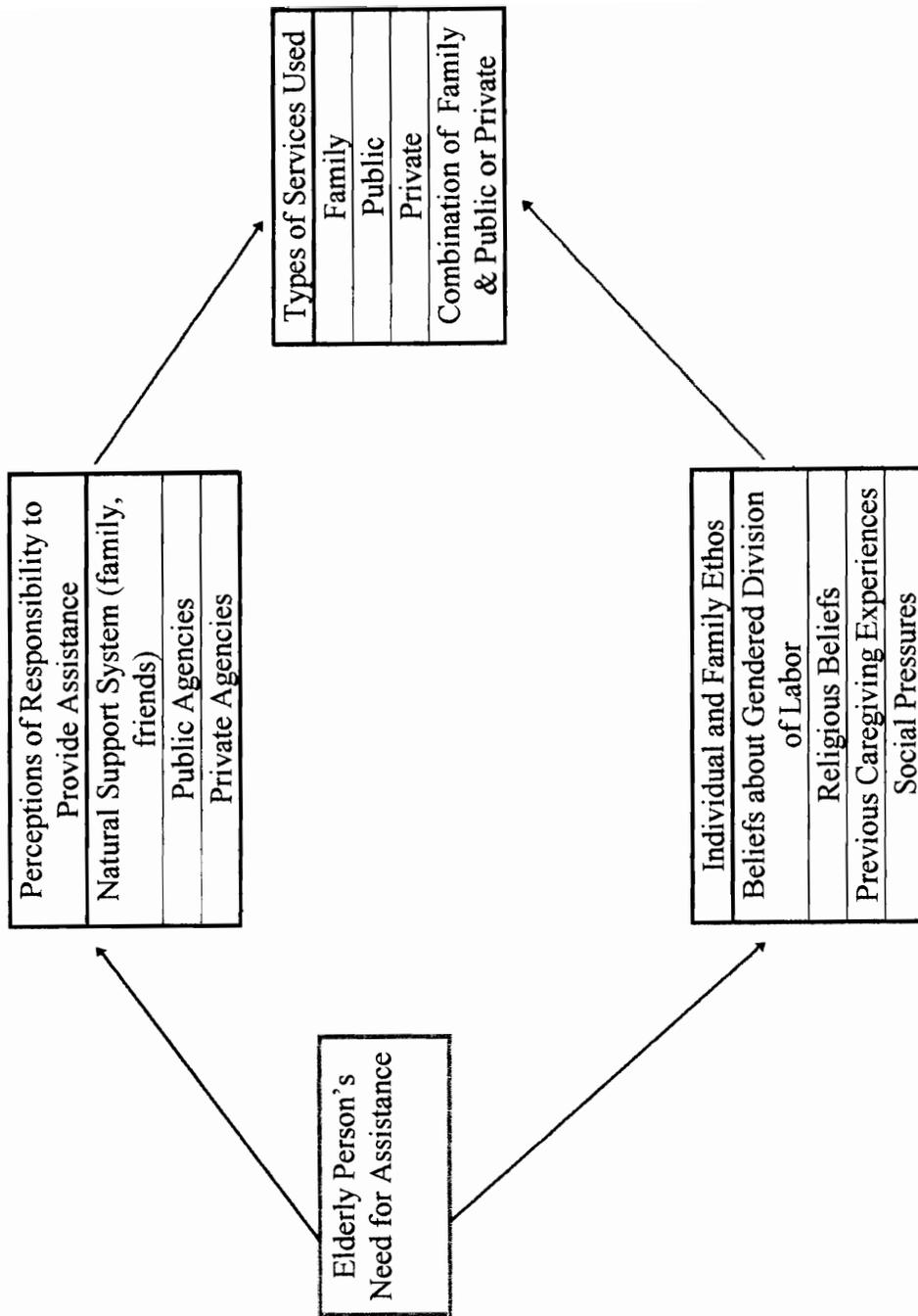
Figure 8. Conceptual Framework for a Study of Family Influences on Caregiving to Aged Parents Adapted from Brubaker and Brubaker (1989)

Types of Services Used

Family
Public
Private
Combination of Family & Public or Private

Perceptions of Responsibility to Provide Assistance

Natural Support System (family, friends)
Public Agencies
Private Agencies

Individual and Family Ethos

Beliefs about Gendered Division of Labor
Religious Beliefs
Previous Caregiving Experiences
Social Pressures

Elderly Person's Need for Assistance

Kosloski's (1992) model provided a better explanation for patterns of service utilization among families in the present study.

Study findings supported Montgomery and Kosloski's hypothesized relationships among family member needs, perceived utility of services, and actual service utilization. Need of the care recipient for assistance was the strongest predictor of use of formal care services, and financial resources predicted which sector, public or private, provided those services. The relationship structure is outlined in Figure 9.

I propose that individual and family ethos have some connection to family members' perceptions of their responsibilities to care for frail members and to the care arrangements that they make for those members. Among families in this study, that arrangement usually combined family and paid assistance. In addition, the factors that comprise individual and family ethos have been modified from the framework depicted in Figure 8.

The components of individual and family ethos derived from this study reflect the predominant themes that emerged from analysis of the data on learning responsibilities and developing a sense of responsibility to older family members. They include parental expectations; family role modeling of care for parents at home; religious training and practice; family rules, both past and present; and family closeness, defined as a close-knit family and shared spousal values. Figure 10 depicts the relationships among the four variables.
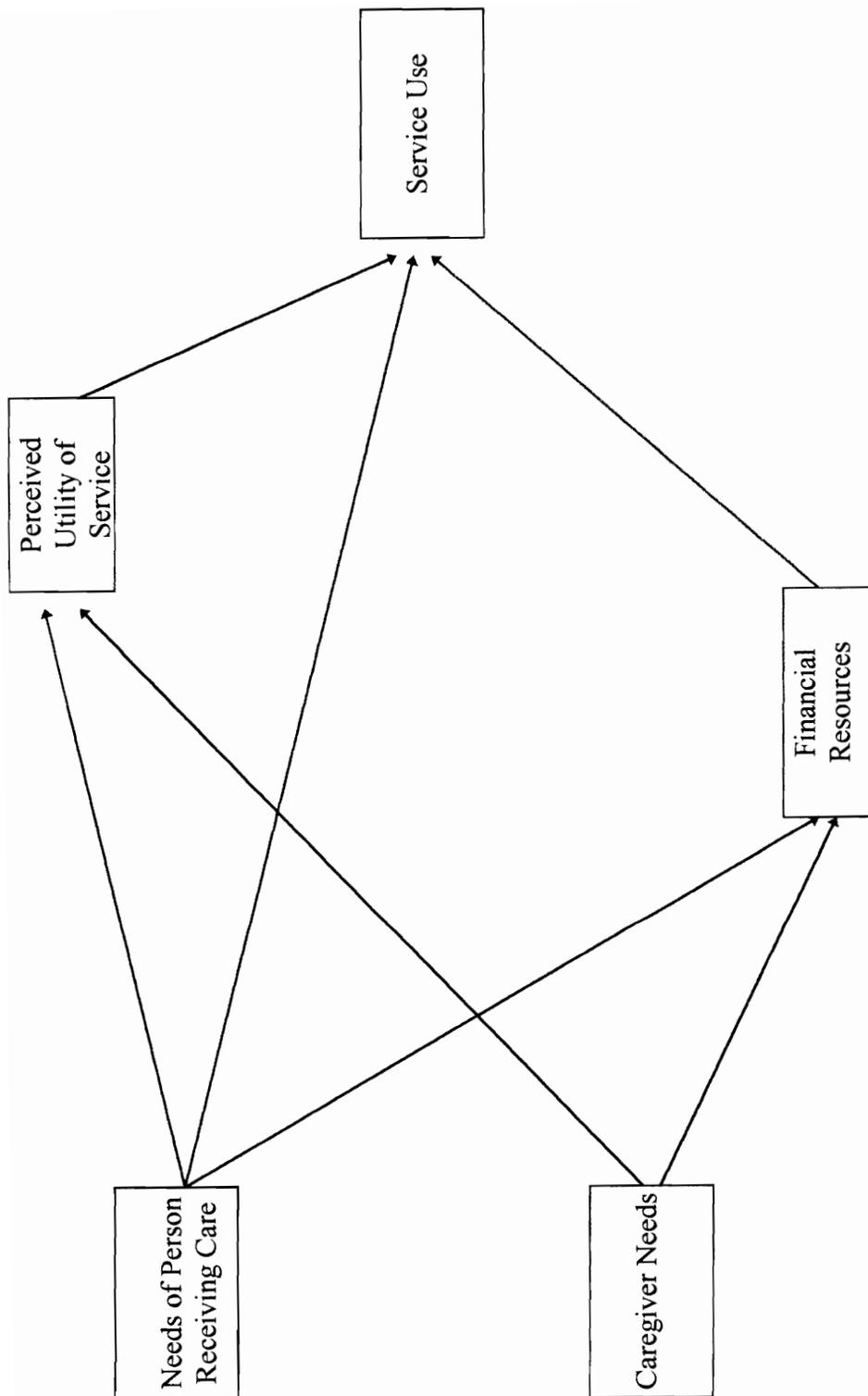
Figure 9. Conceptual Model of Factors Affecting Service Use
Adapted from the Montgomery and Kosloski Model (1992)

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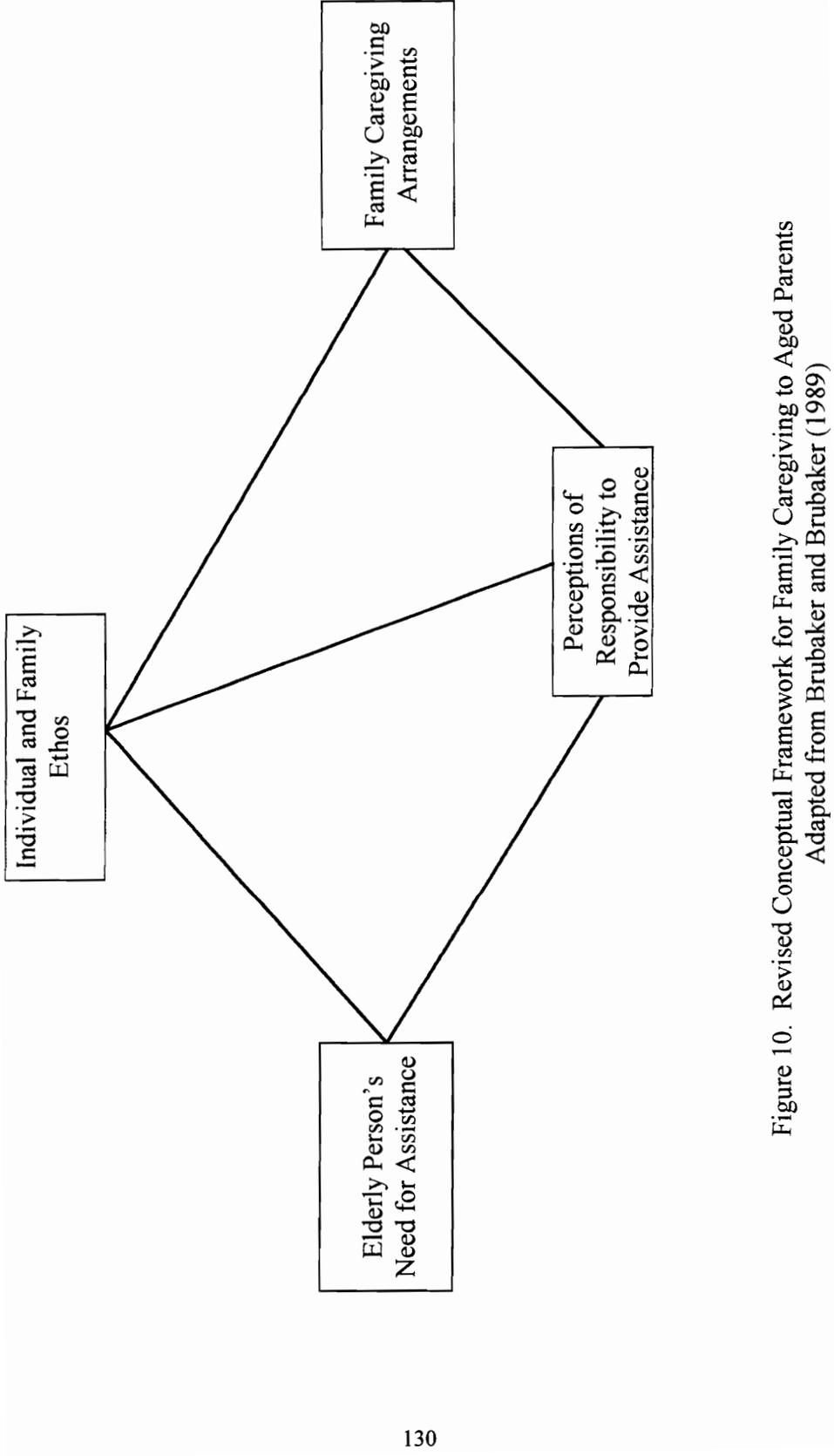
Figure 10. Revised Conceptual Framework for Family Caregiving to Aged Parents
Adapted from Brubaker and Brubaker (1989)

A comprehensive theory of family caregiving is difficult to articulate because of the many types of physical and mental limitations experienced by older family members, the diversity of family structures, and the numerous ways elder care can be arranged by families. In addition, assisting parents presents challenges to the family that are different from those of spousal care. In parent care, balancing the needs of the whole family with the needs of the parent is a significant factor in deciding upon the means of care provision; whereas in spousal care, the needs of the whole family usually assume a lesser role, and the health of the primary caregiver plays a greater role in deciding how care is provided to the dependent spouse. Therefore, mini-theories and conceptual frameworks are likely to do a better job of helping scholars understand family caregiving to older parents, in-laws, and grandparents than a comprehensive theory could do.

Limitations of the Research

The generalizability of the findings of this study to the population of families caring for aged parents at home is somewhat limited due to the small sample size, its non-random selection, the homogeneity of racial background, and the preponderance of non-employed primary caregivers in this sample. Larger samples with families that are racially and ethnically diverse, as well as more highly stratified in terms of socioeconomic status, would increase the applicability of findings to the general population. However, the findings that delineated how families learned and shaped filial responsibilities were consistent across levels of family income and types of family

structures, suggesting that there may be some universal means by which families transmit values and teach individual members to care for their elderly.

The cross-sectional nature of this research limits what can be known about the shaping of filial responsibility and formal service utilization patterns over the entire period of time spent in caring for dependent parents. This study tapped the input of families at differing stages of their caregiving careers; families had been caring for their older members for periods of six months to nearly 10 years at the time they were interviewed for this research project. A longitudinal design that included interviews with family members at several points in their caregiving careers would yield valuable information about the continuous shaping of a sense of responsibility and patterns of formal care usage over time.

Implications for Policy and Practice

Many scholars have suggested that long-term care policy for both disabled and elderly persons in the United States is badly in need of reform (Gonyea, 1995; Hooyman & Gonyea, 1995; Kane & Penrod, 1995; Stone, 1991). In discussing familial obligation to the elderly, Stone (1991) asserted that "the key question in the 1990s is...what can be done to support and enable families to continue providing care" (p. 47). America has no coherent long-term care policy for its elders, and the services that are available to older persons and their families are fragmented and difficult to access (Hooyman & Gonyea, 1995; Kane & Penrod, 1995).

Home care workers were the most frequently used service by the families in this study. They played a vital role in families' abilities to keep their older parents at home. The need for this type of care is clear; yet, because the functional limitations of elderly persons do not necessarily constitute an acute health care problem, it is not considered medically necessary. As a result, neither Medicare nor most private insurance policies will pay for this service (Hooyman & Gonyea, 1995). Most of the families in this study were affluent enough to pay for this service. One family was receiving its home care worker through the South Carolina Community Long Term Care program, which relies upon a Medicaid waiver to offer the service to low-income elderly people. But this program has a waiting list that averages six months statewide. A recent study of clients on the waiting list reported that more than half of them (numbering in the thousands) could be helped by the services of a personal care aide (S.C. State Health and Human Services Finance Commission, 1993).

It is clear that under current conditions, access to home care workers is compromised to all but the affluent members of American society. If family care of the elderly is to continue to predominate, long-term care policy needs revision. Gonyea (1995) proposed that coalitions be built between those who advocate for disabled persons and those who advocate for elderly persons in order to promote development of a system of long-term care insurance that is based upon functional limitations rather than age groupings. Such coalitions would avoid pitting the young against the old in competition for scarce federal dollars. The practice of offering community-based services to all

disabled persons who need long-term care assistance already occurs at the state level. In South Carolina, for example, Medicaid-eligible persons with disabilities representing all age groups, including children, adults with HIV-AIDS and other disabilities, and elderly adults are served by Community Long Term Care (South Carolina State Health and Human Services Commission, 1993). A comparable approach at the federal level would assist many families in their efforts to keep their elderly parents at home.

<div align="center">Recommendations for Future Research</div>

A unique contribution of this study to the family caregiving literature is the explanation of how family members learned to be responsible for parents and other relatives. Results highlighted the importance of family member expectations, family history, and the fluidity of assumption and performance of caregiving roles. On the basis of this study's findings about parental expectations, researchers should pay close attention to the role of an aging parent's personality and behavior in explaining the development and enactment of filial responsibility. In addition, results of this study highlight the role of religious training in childhood and its strong link to the expression of filial responsibility in adulthood. Future research in family caregiving would be enriched by additional study of the role that religion plays in fostering the development and expression of filial responsibility, as well as its potential importance as a coping strategy for dealing with caregiver stress.

Additional studies are needed to understand the apparent incongruity in respondents' beliefs about who is best suited to provide parent care and their actual

behaviors in parent-care situations. Perhaps the optimal way to study this issue is by use of observational methods, rather than by interview methods. Extended ethnographic observation permits recording and analysis of conversation, as well as behavior patterns related to division of labor in a natural setting. Future researchers might consider such a study design to explore the connection between beliefs and behavior regarding the division of labor in caring for aged parents.

I offer recommendations for two specific research projects on the basis of the findings of this study. One focuses on the role of in-law caregivers; the other examines the role of home care workers in assisting families to care for dependent elderly parents.

In the present study, several daughters-in-law served as primary caregivers, and sons-in-law were frequently involved in a secondary caregiving role. Despite their considerable involvement in caregiving, little research has been conducted with in-laws as the primary focus of inquiry (Globerman, 1996). In addition, the children of several families in this study were responsible for providing some type of assistance to a parent from both sides of the family. Nearly nothing is known about the effects of caring for two parents, one from each side of the family, on their children, or on relationships in the multigenerational family. Yet, the results from this study suggest that such caregiving is not an uncommon occurrence. Therefore, a study of families caring for parents from both sides of the family, with a focus upon in-law involvement, is recommended. Data from such a study could enable researchers to examine the nature of filial responsibility in a two-parent caregiving situation, the unique stressors associated with this condition, and

the caregiving arrangements made by the couples. Such a study could test the finding from the present study that a long-term positive relationship with the parent-in-law enhances the willingness of the son or daughter-in-law to care for the parent-in-law at home.

I also suggest a study of home care workers, specifically the type of personal care aides used by half the families in the present study. The National Institute on Aging has called for research on home care for the elderly, including low technology/custodial care (National Institutes of Health, 1992). The NIA wants to learn more about the nature of such care, its prevalence in elder home care, the process of home care from perspectives of both clients and family caregivers, and outcomes of this type of care in terms of quality and effectiveness.

Other researchers have suggested that additional research in this area of family care and service utilization is needed. Fischer and Eustis (1994) limited their study of home care to adult clients with physical disabilities, and included all age groups in their sample. In part, these delimitations may account for their finding that families had little or no interaction with home care workers. In the present study, families had considerable interaction with home care workers, from the recruitment and hiring process to the daily care routine. Having older family members with both cognitive and physical impairments is very likely to require persistent family caregiver involvement. The results of the present study suggest that use of home care workers leads to positive outcomes for both clients and families in terms of satisfaction with services and increased ability to

focus attention upon the needs of multiple family members while caring for the parent at home.

I recommend a study of home care workers and their elderly clients and families that is large in scope and that focuses upon both process and outcomes for clients and their families. Some questions that could be explored include the prevalence of use of agency-based workers versus free-lance workers, the types of tasks performed and frequency of care provided, satisfaction with the work from client and family perspectives, and rates of and reasons for turnover among home care workers. Such a study would further NIA's goal of guiding program and policy decisions and strengthening the current health care system. The project might also build public awareness of the need to support caregiving families with this type of help.

Conclusion

The results of this research affirm the importance of studying multiple generations of families in order to gain insights into how filial responsibility is constructed by individuals over time, and how such values are transmitted from one generation to another in families. Findings also provided evidence of the strength and persistence of the gendered division of labor among families who care for elderly parents. At the same time, the behavior of one family provided evidence that traditional gender roles could be successfully challenged and altered by a combination of parental role modeling, encouragement, and expectations..

Taken together, study findings point to the need for gerontologists to understand caregiving as a process as well as an outcome. While the findings of the present study affirm the importance of family structure, care recipient health, and financial resources as important structural variables, they also suggest that family traditions, values, and communication patterns contribute a great deal to both the choices families make and the processes they follow to provide care to elder members at home. Families creatively construct the caregiving process, a process that is both challenging and ever-changing.

It is also important for the accounts of families living through parent caregiving to become tools to educate both gerontologists and the general public on issues that they may face in their professional and personal lives. One of the respondents ended her interview with the following observations:

> I think what you're doing is important and I hope that the results...can be beneficial to a lot of people, because the way it looks, dementia or forms of dementia seem to be the wave [of the future]....I think people are trying to get information out, but having a first-hand account is going to make a difference, because unless you live in it, unless you are around it, it's hard for other people to understand. So, maybe through all of this information it will be good for other people to be informed.

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Appendix A

<u>Individual Interview Guide</u>

Introductory Statement

I'd like to get your ideas about providing assistance to older family members. I'd like you to answer the questions as completely as you possibly can. Please let me know if you have any questions as we go along.

1.   What is your view or opinion about the part the family should play in providing care for ____(Care recipient's name)?

      Probe:
      What should a family **do** for an older member who needs assistance?

2.   In what ways do you think your views about the part the family should play in providing care to ____(Care recipient's name) are shared by others in the family? In what ways are your views different from those of others in the family?

      <u>Probes:</u>
      Are views more or less intense than others in your family
      Are there any areas of assistance in which your views differ from those of others

3.   What prompted you (others) to get involved in _____(name) or (your) care?

      <u>Probes:</u>
      phone calls from family or care recipient
      concerns or fears for care recipient's welfare
      meetings, discussions with others
      observations that care recipient needed help with housework or other tasks

4.   What things are you currently doing (being done) to help ____(name) or (you)? How long have you been doing these things?

      <u>Probes:</u>
      what types of help are being given, and how often

5.   What things are being done to help ____(Care recipient's name) that you are **not** involved in doing?

6.   What beliefs do you have about how to best care for older members of your family?

Probes:
beliefs about who is best suited to provide help with
the various tasks of caregiving
beliefs about what type of environment is best for the older person in need of assistance

7.   Which of the beliefs you have just described are held in common by family members? Which beliefs are different among family members?

Ask the following question if necessary:

8.   How would other family members not present today describe their views about the part the family should play in providing assistance to ____(Care recipient's name)?

Probes:
what would they say
what has made them view it that way

9.   Who or what has influenced your ideas about your **personal** responsibility to help care for____(Care recipient's name)?

Probes:
personal experiences-with family of origin, family of procreation, professional training, other
relationship with the care recipient
community or societal attitudes
media
religious teachings
expectations of agency or other care providers I have/had contact with

9a.   How were older members of your family treated by other family members?

9b.   What can you recall about their care if they needed assistance?

9c. How have these observations influenced your decision-making about how to care for _____?

10. Sometimes the beliefs of one family member seem to have more influence than those of others in these types of matters. How true of your family is this statement? If this is true in your family, whose beliefs seem to have more influence than those of others? Why? If this is not true of your family, tell me why you think no one member has more influence than others in these matters.

11. How much thought and discussion went into deciding which family members would carry out the various helping tasks?

    Probes:
    did division of tasks seem pretty straightforward, clear?
    were there tasks that required bargaining or negotiation among family members to get them accomplished?

Now I'm going to ask something a little different from what we've just discussed:

12. How have your beliefs about how to provide care for____ (Care recipient's name) affected decisions about whether or not and when you would use the services of agency or other volunteer helpers in the home?

QUESTIONS 13-15 ASKED OF FAMILIES USING AGENCY OR VOLUNTEER SERVICES

13. What were the things that influenced your decision to use agency or volunteer services?

14. How do you feel about the services you are currently (using, receiving)?

    Probes:
    how well you like/dislike their work
    how well their efforts mesh with your helping efforts

15. How has the use of these services affected your perceptions of your responsibilities to help ____(Care recipient's name)?

QUESTION 16 ASKED OF FAMILIES NOT USING AGENCY OR VOLUNTEER SERVICES

16. Have you ever considered using services provided by a local agency, paid or volunteer? If so, what has kept you from using these kinds of services thus far?

    Probes:
    didn't see a need for them
    not enough money to pay for services
    against our beliefs about how to provide care for our family
    services were inconvenient for our situation
    prior negative experience with these types of services
    lack of knowledge about these services
    care recipient does not want someone outside the family helping out

17. How has your family financial situation affected your decisions about how to care for _____?

18. Have your caregiving efforts affected other family relationships? If so, how?

    Probes:
    Can you see any positive ways that others have been affected?

19. What does caring for _____ mean to you personally?

    Probes:
    Does it have any special meaning for you?

20. What do other persons in situations like yours need to know about helping an older family member? Is there anything else you would like to say?

Thank you very much for your time and your participation in this discussion.

Appendix B

Questionnaire

     It is important to me to understand your background as much as possible. Below are several questions I would like you to answer that will give me this important information. Please let me know if anything asked here is unclear to you.

Today's Date:_____

Place: _____

Interviewer's Name: _____

Your Name: _____

Relationship to Care Recipient: _____(please specify
    type of relationship, such as daughter, friend, etc.)

Gender: _____

Date of Birth: _____

Birth Place: _____

Birth Order in your family: 1st__ 2nd__ 3rd__ 4th__ 5th__ 6th__

Brothers: (city & state)
Name: _____ present age_____ lives in_____

Name: _____ present age_____ lives in_____

Name: _____ present age_____ lives in_____

Sisters:
Name: _____ present age_____ lives in_____

Name: _____ present age_____ lives in_____

Name: _____ present age_____ lives in_____

Your Education
highest grade completed _____ (give the number) or
college graduate   _____ (check if applies) or
master's or doctorate   _____ (specify which applies)

Your Present Occupation: _____
                         (type of work that you do;
                         if retired, what you used to do)

Marital Status (check one):

____married
____separated
____divorced
____widowed
____single, never married

Children:
                              (yes or no)
name: _____ age ___ gender ___ living at home ____
name: _____ age ___ gender ___ living at home ____
name: _____ age ___ gender ___ living at home ____
name: _____ age ___ gender ___ living at home ____

Religious preference (denomination) _____

For the next two questions, <u>check</u> the answer that best describes you today.

Quite apart from attending religious services, how important would you say religion or
spirituality is to you?

_____   very important
_____   somewhat important
_____   not important

What is your political party preference?
_____   Democrat
_____   Republican
_____   Independent
_____   Other (please name) _____
_____   None

Appendix C

<u>Contact Summary Form</u>

_____

Contact type:
   Visit _____   Contact date: _____
   Phone   _____   Today's date: _____
            (with whom)   Written by: _____

1.   <u>What were the main issues or themes that struck you in this contact?</u>

2.   <u>Summarize the information you got (or failed to get) on each of the target
        questions you had for this contact.</u>

        <u>Question</u>   <u>Information</u>

3.   <u>Anything else that struck you as salient, interesting, illuminating or important in
        this contact?</u>

4.   <u>What new (or remaining) target questions do you have in considering the next
        contact with this family?</u>

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Educational Experience

Ph.D. Department of Family and Child Development, Virginia Polytechnic Institute & State University. May, 1996.
Dissertation: Family Ties and Care for Aged Parents at Home.
Rosemary Blieszner, Chair.
M.S.W., 1974-Tulane University A.B., Psychology, Cum Laude, 1972-St. Louis University

Employment Experience

Field Study Coordinator, Department of Family & Child Development, Virginia Polytechnic Institute and State University, 1992-1993. Arranged field study experiences for Human Services undergraduate majors; advised students before and during placement with human service agencies. Developed new field study placements and coordinated student experiences with field site supervisors and agency directors. Spoke to orientation classes in the College of Human Resources to acquaint them with the Human Service major, the Field Study component, and careers in Human Services.

Psychotherapist, Private Practice, 1980-1992. Conducted individual, couple, family, and group therapies, with special emphasis on treatment of anxiety and depressive disorders, and personality disorders. Practice included contract to do employee assistance counseling for Personal Performance Consultants, Inc., a national firm offering Employee Assistance Programs to businesses and corporations.

Assistant Professor of Behavioral Sciences, Erskine College-1986-1992. Taught undergraduate courses in sociology and social work. The social work courses included Human Behavior in the Social Environment, Social Welfare Policy, and Interventive Methods I and II. The sociology courses included a survey course in Introductory Sociology, Social Problems, and Drug and Alcohol Abuse Prevention. I also served on a faculty and staff review committee during the school's self-study for re-accreditation.

Emergency Assistance Programs Coordinator, Greenville Mental Health Center, 1975-1980. Coordinated both telephone crisis and walk-in clinics for an outpatient community mental health center. Also performed individual and group therapies, and served as a community consultant and educator for the Center's consultation and education unit. Developed and taught courses in assertiveness training and stress management to community members and local businesses.

Professional Credentials

Licensed Independent Social Worker in **South Carolina** since 1989 (highest level   of licensure available).
Academy of Certified Social Workers since 1976.

Professional Organization Memberships

Gerontological Society of America, 1994-Present
Southern Gerontological Society, 1993-Present
National Council on Family Relations, 1992-Present
     Families and Health Section Activities
     Presider, "Health Issues of Families with Chronically Ill Older and Middle
     Adults", 1995 Annual Conference
     Abstract Reviewer, 1995 Annual Conference
     Nominations Committee Member, 1995
National Association of Social Workers, 1975-Present
     Chair, Nominations Committee, South Carolina NASW, 1991-1992.
South Carolina Society for Clinical Social Work, Founding member, 1985-Present.
     President, 1988-1989.

Awards and Support

Training Stipend-South Carolina Department of Mental Health, 1973. Awarded full tuition and fees, plus monthly salary to attend Tulane University MSW program.

Inter-university Consortium for Political and Social Research (ICPSR); Summer Program in Quantitative Methods, University of Michigan: Awarded stipend to attend National Institute on Aging-sponsored workshop on the Wisconsin Longitudinal Study, July, 1995

Graduate Student Assembly, Virginia Polytechnic Institute and State University-Awarded Graduate Research Development Project grant to complete dissertation research, September, 1995.


Presentations

Piercy, K. W. (1993, February). Divorce law and related reforms. Paper presented at the meeting of the Southeastern Council on Family Relations, Atlanta, Georgia.

Piercy, K. W. (1993, April). Post-retirement employment. Paper presented at the meeting of the Southeastern Symposium on Child and the Family, Auburn University, Alabama.

Piercy, K. W. (1995, November). Career Change at Mid-Life: Opportunity, Diversity, and Challenge. Roundtable presented at the annual meeting of the National Conference on Family Relations, Portland, Oregon.

Publications

Piercy, K. W. (1994). Reforming the revolution: Responses to the consequences of divorce law reform. Family Perspective, 28, 155-167.

Kathleen Walsh Piercy