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UNIVERSITY OF CALIFORNIA

Los Angeles

The Decision to Institutionalize
Among Nursing Home Residents and their Children in Shanghai

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Social Welfare

by

Lin Chen

2013

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ABSTRACT OF THE DISSERTATION

The Decision to Institutionalize Among Nursing Home Residents and their Children in Shanghai

by

Lin Chen

Doctor of Philosophy in Social Welfare

University of California, Los Angeles, 2013

Professor Lené Levy-Storms, Chair

A rapidly growing aging population, the one-child policy, and the Economic Reform in urban China pose unprecedented challenges to its ingrained tradition of family caregiving. An increasing number of elders in Shanghai have entered nursing homes to meet their needs for long-term care. The contradiction between self-reliant caregiving tradition and growing nursing home utilization calls for an exploration of how these elders and their children decide to institutionalize. Integrating crisis theory, social identity theory, and uncertainty management theory, this study proposes a framework to conceptualize the phases of this decision-making process.

This phenomenological study retrospectively described both generations' experiences of deciding to institutionalize. The author conducted semi-structured interviews with 12 dyads of matched elders and their children (total $N = 24$) in a government-sponsored, municipal-level nursing home in Shanghai. From a dyadic perspective, data analysis emphasized the relational

aspects of participants' intergenerational communication about reaching consensus on institutionalization.

In accordance with a phenomenological approach, the essence of participants' experience of deciding to institutionalize is that elders and their children proactively or reactively chose institutionalization. Decision-making occurred in the face of family caregiving crises, such as elders' declining health conditions, disrupted caregiving arrangements, and strained intergenerational relationships. Proactive families chose institutionalization to prevent potential caregiving pressure that might exceed family caregiving capacity, while reactive families sought institutionalization after they had encountered tremendous caregiving pressure and depleted caregiving resources. Within dyads, each generation, respectively, had its own motivation to institutionalize while preserving positive social identity in intergenerational communication, but ultimately children held decision-making power. When family caregiving crises occurred, filial piety may have become less practical for children, though it remained an integral part of the decision-making process.

This study addresses the importance of catering to various needs for long-term care of Chinese elders—the world's largest aging population in the coming decades. This study informs policy to develop diverse and specialized home- and community-based long-term care in urban China and emphasizes social work practice to establish specific needs assessment criteria, improve overall caregiving communication, advocate for elders' decision-making autonomy, and enhance geriatric training for frontline workers.

The dissertation of Lin Chen is approved.

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To Dad

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ACKNOWLEDGEMENTS

Dad, you must look down at me, smiling. I miss you, though it will never seem like it was enough... Mom, thank you for your blind love and faith in me... This dissertation is dedicated to you and dad.

Lené, I do not know how to adequately express my deep appreciation for everything over these incredibly amazing five years. You are my committee chair, mentor, advisor, and friend. You genuinely care about my research and professional development. If you had not kept pushing my boundaries, I would have not become a stronger researcher and person. Thank you!

I am truly blessed by this dissertation committee who walked me through this study: Dr. Laura Abrams, thank you for all the guidance of qualitative methods and data analysis; Dr. Ted Benjamin, thank you for all the sage advice you have lent me since my publishable paper and those last-minute reference letters; and Dr. Marjorie Kagawa-Singer, thank you for all the unconditional support from my publishable paper to my job applications, and getting my ears pierced for your class assignments was truly memorable. I would also thank Dr. Todd Franke for supporting the IRB application of this study and Dr. Yeheskel Hasenfeld for commenting on an early version of the proposal of this study.

I would also extend my gratitude to the professors and staff in the Department of Social Welfare. I would especially like to thank Dr. Jorja Leap for numerous reference letters for my job applications. Dr. Alfreda Iglehart, Dr. Ailee Moon, and Dr. Fernando Torres-Gil, thank you for advising my nascent research ideas relating to this study in the first year.

My doctoral study could not have been completed without some very generous people: all the elders and their children who graciously agreed to participate in my research; the nursing homes who allowed me to conduct research; my undergraduate advisor, Dr. Wei Sha, who

helped me contact these nursing homes; the Department of Social Welfare; the Dissertation Year Fellowship from UCLA Graduate Division; the Pre-Doctoral Fellowship from UCLA Asia Institute; the Pearl Wang Fellowship from UCLA Asian American Studies Center for two consecutive years; and the UCLA East Asian Library helped me to cover rent for three years.

My colleagues and friends in the program provided me with invaluable support: Leah Hanzlicek, Jason Harley, and Gina Rosen. We shared the most as we came in the program together; Lila Jihanian and Nancy Takahashi, we helped each other over this long haul; Linda Lee, we survived from 296 undergrads in 2012 Spring; and Lesley Harris, spending my birthday with you in New Orleans in 2010 was more memorable than my presentation at GSA.

I would like to express my heartfelt appreciation to my friends who have put up with me even when I could barely put up with myself. Moira Donnelly, you literally participated in each stage of this dissertation; Yijue Hu, you are my person in Shanghai; Yi Li, you understand me even better than I can understand myself; Siwei Liu, you are a rock star; Kuei-chen Lin, you kept me sane throughout the writing process; Xin Shen, I cherish the special bond we have had since England; Haoyi Wang and Zong Wei, you two are families to me in the city 6,497 miles away from home; Yan Wang, how wonderful your baby girl Athena was born on my graduation day; Ge Wen, you are always my emergency contact; Yi Wu, sharing ups and downs with you makes life more bearable; Minzhi Ye, working with you has been a delight and I look forward to more co-authorships; and the 10 buddies from WLZ, you guys were great comfort during data collection over summer 2012. Thank you all for keeping me whole with constant and unconditional friendship. Special thanks to Jialin Lu, you and your family are a wonderful guardian angel for my mom and me!

Finally, Takuya Kimura, thank you for being fabulous.

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Chen, L., & Ye, M. Z. Happily aging: Elderly users' satisfaction with a community-based social support service program in Shanghai. Poster presented at: The 18th UCLA Annual Research Conference on Aging, Los Angeles, CA, June 28, 2013.

---, & Ye, M. Z. (2013). The role of children's support in elders' decisions to live in a yanglaoyuan (residential long-term care). *Journal of Cross-Cultural Gerontology*, 28(1), 75–87. doi: 10.1007/s10823-012-9185-y.

---, & Levy-Storms, L. How to communicate and 'connect' with Alzheimer's: A practical strategy for family visitors of relatives with dementia. Poster presented at: Creative Communication, Gerontological Society of America's 65th Annual Scientific Meeting, San Diego, CA, November 15, 2012.

---, & Levy-Storms, L. How to communicate and 'connect' with Alzheimer's: A practical strategy for family visitors of relatives with dementia. Poster presented at: The 17th UCLA Annual Research Conference on Aging, Los Angeles, CA, June 5, 2012.

---, & Ye, M. Z. Caregiving decision-making among elderly Chinese in Shanghai: Findings from quantitative and qualitative data. Poster presented at: Family Caregiving, Gerontological Society of America's 64th Annual Scientific Meeting, Boston, MA, November 21, 2011.

---. (2011). Elderly residents' perspectives on filial piety and institutionalization. *Journal of Intergenerational Relationships*, 9(1): 53–68.

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---. Elderly residents' perspectives on filial piety and institutionalization in Shanghai. Poster presented at: The 15th UCLA Annual Research Conference on Aging, Los Angeles, CA, June 14, 2010.

CHAPTER I

Introduction

This chapter introduces a broad historical background and contemporary social context for this study. First, it will introduce the socio-demographic changes in modern China. Then it will compare long-term care services in the United States and urban China. Finally, it will define the research problem for this study.

History of Chinese Socio-Demographic Changes

China, the largest developing country in the world, is facing a rapidly growing aging population with overwhelming long-term care needs (Arnsberger, Fox, Zhang, & Gui, 2000), propelled by increasing standards of living by economic status and combined with the distorted demographic results of the one-child policy (Kissinger, 2011). By 2050, more than 30% of China's population is projected to be 65 and older, which is roughly equivalent to the current 316 million population of the United States (United States Census Bureau, 2013; Hayutin, 2008).

In 1949, when the Communists came to power, China's total population was less than half of its current size, at 541.7 million (Zhang & Goza, 2006). However, Mao Zedong (or Mao Tsu-Tung) believed that the larger the population, the more power the country would have to fight against capitalism (Kissinger, 2011). Neo-Malthusians in China, who advocated for population control to ensure resources for future populations (Marsh & Alagona, 2008), were stifled and, as a result, the population nearly doubled over the next 25 years (Zhang & Goza, 2006; Greenhalgh, 2005). This Chinese baby boomer generation was mainly born from the 1950s to the 1960s (Greenhalgh, 2005). For example, between 1953 and 1964, the country's population swelled by an additional 112 million (Riskin, 2000).

After Mao died, the next leader, Deng Xiaoping initiated modernization (i.e., the Economic Reform), leading China to become the world's second-largest economy (Kissinger, 2011). Foreseeing the potential threat of the rapidly growing population to Chinese economic development, Deng adopted a strict family planning policy (i.e., the one-child policy) in 1978 (Greenhalgh, 2005; Zimmer & Kwong, 2003). This policy has been applied within the Han ethnic group, which is the largest single ethnic group in the world, accounting for 92% of the total Chinese population (Greenhalgh, 2005). Consequently, China's total fertility rate dropped from about 7.5% in 1963 (Poston & Duan, 2000) to 1.5% in 2011 (Population Reference Bureau [PRB], 2011).

The decreasing fertility rate, combined with Chinese baby boomers, has created a "4-2-1" phenomenon (Sun, 2004; Zimmer & Kwong, 2003). That is, one child has to take care of his or her two parents and four grandparents. This "4-2-1" phenomenon may aggravate the difficulties in meeting the needs for elder care due to the fewer number of children in the family. This upside-down family pyramid may disrupt the Chinese family caregiving tradition (Zhan, Feng, & Luo, 2008). So investigating how Chinese baby boomers and their parents, the "2" and the "4", conceptualize changes in caregiving arrangements may offer insight into the development of Chinese long-term care policy in order to face the approaching "grey tsunami" of Chinese baby boomers (China National Committee on Aging, 2009).

Long-Term Care in the United States and Urban China

Long-term care refers to a broad spectrum of paid and unpaid and medical and non-medical care for people who have a chronic illness or disability (Kaiser Family Foundation, 2011; Medicare.gov, 2011a; Feder, Komisar, & Niefeld, 2000). Long-term care is different from acute

care, which provides temporary, episodic services, but focuses on curing an illness or restoring an individual to a previous state of better health (Stone, 2000; Kane, Kane, & Ladd, 1998).

Long-term care is a way to integrate treatment and living for elders and people with disabilities over time in order to incorporate healthcare into daily lives (Stone, 2000; Kane et al., 1998).

Declines in the ability to maintain activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) are the primary reasons for elders needing long-term care (Jones, Dwyer, Bercovitz, & Strahan, 2009; Feder et al., 2000). ADLs are routine tasks of life, usually including eating, bathing, dressing, getting into and out of bed or a chair, and using the toilet (Gaugler, Kane, Kane, Clay, & Newcomer, 2003; Feder et al., 2000). IADLs are additional activities necessary for independence, including walking around, laundry, housekeeping, phone use, preparing meals, shopping for groceries, going places outside of walking distance, and managing money (Gaugler et al., 2003; Feder et al., 2000). The National Long-term Care Survey (NLTC) in the United States defines the criteria for institutionalization as being disabled in any of six ADL tasks and any of eight IADL tasks for 90 days or more (Manton, Gu, & Lamb, 2006).

In the United States, at least eight types of long-term care exist to meet elders' increasing needs at various stages: community-based services (e.g., adult day care, senior centers), home healthcare (e.g., homemaker/health aides, personal care aides), in-law apartments, housing for aging and disabled individuals, board and care homes, assisted living, continuing care/retirement communities, and nursing homes, though gaps remain in addressing the overwhelming needs of its aging population (Medicare.gov, 2011b; Jones et al., 2009). Table 1 provides detailed definition of each type of long-term care and their ranges of costs (Medicare.gov, 2011b).

Table 1

Types of Long-Term Care in the United States¹

| | Definition | Range of costs |
|--|---|----------------|
| Community-based services | Communities provide services and programs to help elders and people with disabilities with a variety of personal activities. | Low to medium |
| Home health care | Family members, friends, and/or licensed health workers help elders and people with disabilities need with personal activities (e.g., bathing, dressing, cooking, and cleaning) at home. | Low to high |
| In-law apartments | This housing arrangement provides a living space for a caretaker to take care of elders and people with disabilities with personal activities (e.g., bathing, dressing, cooking, and cleaning). | Low to high |
| Housing for aging and disabled individuals | This housing program helps pay for housing for older people with low or moderate incomes ² . It also offers help with meals and other activities like housekeeping, shopping, and doing the laundry. | Low to high |
| Board and care homes | This group living arrangement provides help with activities of daily living such as eating, bathing, and using the bathroom for people who cannot live on their own but do not need nursing home services. | Low to high |
| Assisted living | This group living arrangement provides help with activities of daily living such as eating, bathing, and using the bathroom, taking medicine, and getting to appointments as needed. Residents live in their own rooms but normally have meals together. | Medium to high |
| Continuing care/retirement communities | This community arrangement provides different levels of care for elders and people with disabilities. In the same community, there may be individual homes or apartments for residents who can live independently, an assisted living facility for people who need some help with daily care, and a nursing home for those who require higher levels of care. | High |
| Nursing homes | These facilities provide care to people who cannot be cared for at home or in the community with a wide range of services. | High |

¹ The table is modified based on information from <http://www.medicare.gov/longtermcare>

² Low to moderate incomes mean less than \$46,000 if single or \$53,000 if married.

Recently, the American long-term care landscape has shifted away from nursing home care and toward home- and community-based services, despite a cumulative 40% likelihood of institutionalization for elders aged 65 and over (Feng, Fennell, Tyler, Clark, & Mor, 2011a; Medicare.gov, 2011a; Jones et al., 2009). Community-based long-term care has flourished in the United States as an alternative to nursing home care to meet financing constraints and to better accommodate individuals' preferences for staying at home (Feng et al., 2011a; Gu & Vlosky, 2008; Schwab, Leung, Gelb, Meng, & Cohn, 2003). Many states use the Medicaid 1915(c) waivers, authorized in 1981 in the Social Security Act, to “rebalance” long-term care—that is, to achieve a better balance between institutional and non-institutional services and to alleviate elderly consumers' financial pressure (Feng et al., 2011a).

In contrast to the United States, Chinese long-term care is at its nascent stage. The Chinese government faces urgent needs for long-term care of the rapidly growing aging population, including developing a safety net program nationwide, standardizing welfare institutions, and creating geriatric training programs (Li, 2011). Traditionally, government-sponsored and -managed long-term care services have been the only formal arrangement to support the mentally ill, the impoverished, and “*three-Nos*” elders (i.e., no child, no income, and no spouse; Wong & Leung, 2012; Feng et al., 2011b). However, resources remain scarce for other groups who need ample long-term care services, for example, frail elders.

The proportion of unmet and under-met needs for long-term care of Chinese elders is nearly 60% or about 3.5 million based on the analysis of the 2005 wave of the Chinese Longitudinal Healthy Longevity Survey (CLHLS; $N = 15,593$; Gu & Vlosky, 2008). This number could increase to 16 million elders in 2050 given the current aging rate in China (Gu & Vlosky, 2008). More than 80% of long-term care in China is family caregiving, and family

members pay for more than 50% of long-term care costs (Gu & Vlosky, 2008). Most recently, the Chinese government has amended the Law of Protection of the Rights of the Elderly, regulating adult children's visits to their elderly parents in order to deal with the growing problem of lonely elders (Hatton, 2013). This amendment may be policy effort to face the recent declines in family caregiving for Chinese elders, from about 15% in 1984 to 12% in 2004 (Houser, Gibson, Redfoot, & AARP Public Policy Institute, 2010).

In reality, less than 10% of Chinese elders seek formal long-term care (Feng et al., 2011b), though this rate has been growing in recent years (Chu & Chi, 2008; Wu, Carter, Goins, & Cheng, 2005). Understandably, most Chinese elders prefer family caregiving to formal long-term care, due to the ingrained filial piety tradition³ (Feng et al., 2011b; Feder et al., 2000), which entails respecting, obeying, and supporting unconditionally elderly parents (Chou, 2011; Ng, 2002). Their low utilization of formal long-term care may also relate to the fact that most long-term care infrastructure in urban China is still in its rudimentary stage and without much government support (Feng et al., 2011b).

Hiring paid caregivers is the most common alternative to supplement family caregiving. However, families do not prefer this option because those paid caregivers normally do not have any healthcare training (Wu et al., 2005). Community-based long-term care for elders, both private and government-sponsored, such as adult day care and senior centers, has just begun to emerge (Wu et al., 2005). Hospitals specializing in geriatrics have barely begun to develop, and elders or their children have to pay out of pocket (Feng et al., 2011b; Chen, Yu, Song, & Chui, 2010). In addition, after long hospital stays, elders are discharged home without any institutional or community-based post-acute care (Flaherty et al., 2007). Nursing home care has not yet emerged as a culturally-viable long-term care option for most Chinese elders, largely because of

³ Chapter II provides a detailed review on filial piety.

its deeply-rooted, stigmatized impressions from original mentally ill, impoverished, and “*three-Nos*” residents (i.e., no child, no income, and no spouse; Wong & Leung, 2012; Feng et al., 2011b). These stigmas relate to a lagging development in nursing home facilities (Feng et al., 2011b; Chu & Chi, 2008; Zhan et al., 2008; Tse, 2007; Lee, Woo, & Mackenzie, 2002). After all, there is no network of geriatric medical services covering family medical treatment, community-based geriatric services, geriatric sections in general hospitals, or geriatric hospitals in urban China (Chen et al., 2010). Fundamentally, Chinese long-term care has a limited range of available services for the increasing aging population, compared to those in the United States (see Figure 1).

However, Shanghai, one of the largest cities by population in the world, has currently experienced a record-setting increase in the aging population as well as nursing home care. Elders aged 65 and over accounted for 25.7% of the city’s overall 23.5 million population in 2012 (Shanghai Statistic Bureau, 2013; Social Welfare Department of Shanghai Civil Affairs Bureau, 2013). The average life expectancy was 82.41 years in Shanghai in 2012, while the fertility rate has remained negative for the past 15 years (Shanghai Statistic Bureau, 2013).

Likewise, the number of nursing homes in Shanghai has increased nearly 25%, from 505 in 2006 to 631 in 2012 (Social Welfare Department of Shanghai Civil Affairs Bureau, 2013). The number of nursing home beds has increased almost 50%, from approximately 60,000 in 2006 to more than 105,000 in 2012 (Social Welfare Department of Shanghai Civil Affairs Bureau, 2013). The newly increased number of nursing home beds was almost 6,000 in 2012 alone (Social Welfare Department of Shanghai Civil Affairs Bureau, 2013). This tradition-contradictory situation calls for an exploration of how these elders and their children decide to institutionalize.

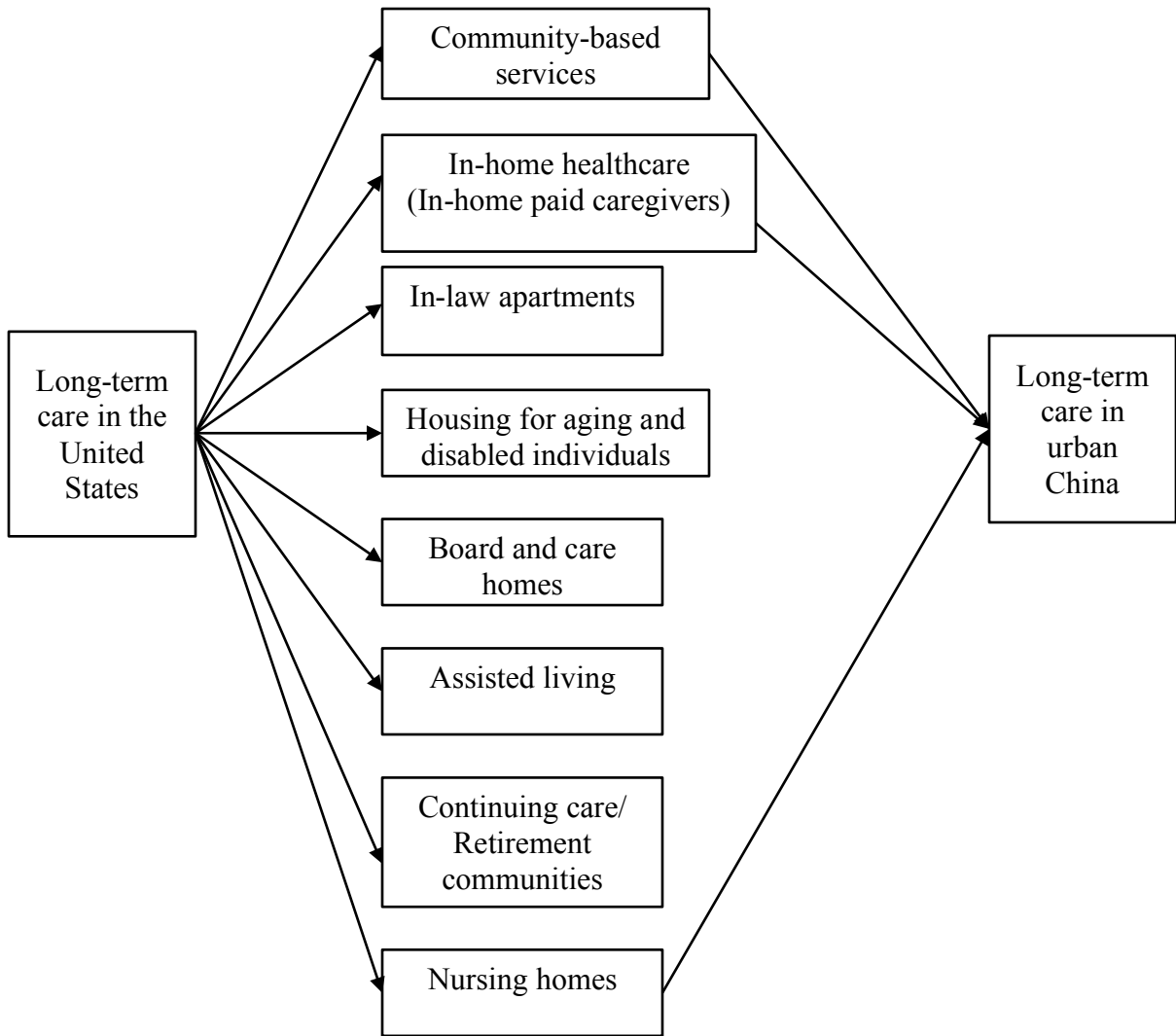


Figure 1. Available long-term care in the United States and urban China.

Research Problem

Deciding to institutionalize has been found a complex and difficult process for elders and their families in Western societies (Hoving, Visser, Mullen, & Borne, 2010; Byrne, Goeree, Hiedemann, & Stern, 2009; Bongaarts & Zimmer, 2002; High & Rowles, 1995). This decision typically has psychosocial costs for elders and their children, which come from wider social contexts (Byrne et al., 2009), such as allocation of time to family caregiving and work (Byrne et al., 2009), lack of and/or burn-out of informal caregivers (Yamamoto & Wallhagen, 1998; Sauvaget, Tsuji, Fukao, & Hisamichi, 1997), knowledge of caregiving (Hicks & Lam, 1999), and a culturally-diverse aging population (Hoving et al., 2010).

Besides similar contexts with the Western societies, filial piety is a unique contextual factor that cannot be ignored in Chinese society and caregiving. Filial piety has a fundamental impact on families' decision to institutionalize elderly Asian parents (e.g., Chang & Schneider, 2010; Tse, 2007). This impact is both lingering and compelling, such that even the second and third generations of Korean immigrants feel ashamed about institutionalizing elderly parents *in the United States* (e.g., Kim, Cho, & June, 2006; Park, Butcher, & Maas, 2004) where filial piety may not be as strong as it is in Asian societies. However, children, the traditionally expected caregivers in urban China, have become less available for their elderly parents because of reduced family size, geographic mobility, and conflicting work and family obligations (e.g., Chen & Ye, 2013; Zhan et al., 2008; Lee & Kwok, 2005), which has been to the advantage of the younger generation and to the disadvantage of the older generation (Ikels, 2004). All these contextual factors may explain the increasing utilization of nursing home care in urban China.

Existing research in social welfare and public health has yielded limited information on the decision-making process around institutionalization. First, large-scale studies have found

predictors of elders' institutionalization, based on children's perspectives, such as declining ADLs and IADLs, diagnosis of dementia, bladder incontinence, falls, and behavioral issues (e.g., aggression, wandering; Gaugler, Yu, Krichbaum, & Wyman, 2009; Martikainen et al., 2009). But the nuances of decision-making dynamics between generations remain understudied. Second, qualitative studies on this topic often focus only on how child caregivers decided *for* their elderly parents with dementia (e.g., Chang & Schneider, 2010; McLennon, Habermann, & Davis, 2010). Issues of institutionalizing elders with dementia are clearly important, but investigating the institutionalization of cognitively-intact elders can become the starting point for examining caregiving decision-making dynamics among family members. Third, studies specifically focusing on the decision to institutionalize elders in urban China are rare. Existing studies have only investigated a single generation, such as the elders (e.g., Chen, 2011) or the children (e.g., Zhan et al., 2008). How both generations' perspectives mutually influence this decision, how psychosocial contexts influence this decision, and how both generations communicate with each other to reach consensus on institutionalization remain unclear.

Therefore, this study hypothesizes that for elders and their children in Shanghai, the decision to institutionalize involves different caregiving perceptions from each generation and a range of diverse, evolving contextual factors. From a retrospective glance, this phenomenological study aims to describe what elders and their children experience during this decision-making process. Specifically, it focuses on how both generations perceive caregiving crises, intergenerational communication, and uncertainty management during the process and explores how the current socioeconomic contexts in urban China may affect families' perceptions and utilization of institutionalization.

In terms of long-term care policy, this study illuminates how filial piety has evolved and its implications for caregiving arrangements for both generations and addresses the needs for tailored and specialized home- and community-based long-term care in order to alleviate family caregiving pressure. In terms of social work practice, this study provides support for developing relatively more explicit needs assessment criteria, advocating for elders' autonomy in caregiving decision-making, establishing knowledge-based training programs for frontline workers, and enhancing healthcare communication in the overall caregiving relationships.

The next chapter will provide a social context for this study, review the existing literature about the decision to institutionalize, and identify research gaps in this topic.

CHAPTER II

Literature Review

The purpose of this chapter is to provide a context for this study and to review the existing literature on the research problem. First, it will discuss the social context for the decision to institutionalize in urban China. Second, it will present the current status of nursing home care for elders in urban China. Finally, it will identify research gaps in investigating the decision to institutionalize among elders and their children.

The Social Context of Urban China

Filial piety. Filial piety has been considered the most important virtue of Confucian culture (Fei & Chang, 1945). It has been the foundation for all Chinese social norms and cultural values even before Confucius time (400 B.C.⁴; Ikels, 2004; Wang, 2004; Ishii-Kuntz, 1997).

Filial piety refers to the notion that the younger generation should obey the older generation and should fulfill the older generation's needs for both material and emotional support at any costs and under any circumstances (Chou, 2011; Cheung & Kwan, 2009; Lai, 2007; Lee & Kwok, 2005; Ikels, 2004; Ding & Ye, 2001; Chen & Silverstein, 2000; Lee, Parish, & Willis, 1994).

Filial piety, as a prestigious virtue, has profoundly contributed to the establishment of a parent-centered caregiving tradition and norm in Chinese history (Ikels, 2004; Chen, 1996).

Historically, filial piety had social-political significance in maintaining governance and regulating social hierarchy since Han Dynasty (206 B.C.; Chang & Kalmanson, 2010; Chen, 1996). The concept was used to juxtapose the hierarchies of the people's submission to the king,

⁴ Confucian classic *Xiao Jing* or *Classic of Xiào*, written by Confucius and his students, is about the concept of filial piety, *xiào*, and how to use it to set up a harmonious society (Chang & Kalmanson, 2010; Ikels, 2004). But the concept of filial piety had actually existed several dynasties before Confucian time but not been systematically recorded (Chang & Kalmanson, 2010).

children to their parents, and wives to husbands (Chen, 1996). As such, Chinese social relations were innately hierarchical, and filial piety governed these hierarchical relations based on status and authority within the parent-child relationship (Zhang, Harwood, & Hummert, 2005).

In particular, the younger generation had to conform to the hierarchical status regulated by filial piety in order to maintain parent-child relationship harmony. This relationship harmony emphasized male-dominated privilege. Sons, especially, have often been viewed as an individual's "insurance" for old age, as indicated by the old Chinese saying "*Yang Er Fang Lao.*" That is, sons will provide caregiving when parents become old and frail (Chen, 1996; Rubinstein, 1987). However, women at home, such as wives, daughters, and daughters-in-law, fulfill the actual caregiving responsibilities, especially because of their lower status in the family and society in the past. In the Chinese caregiving tradition, the equation of "community care = family caregiving = cared for by women" is a loose interpretation of filial piety (Chen, 1996). Thus, family members, especially women, remain the primary—sometimes the only resource—for Chinese elders to rely on (Chan, Cole, & Bowpitt, 2007; Ikels, 2004). In other words, Chinese women are reliable caregivers; men are not.

Filial piety has been at the core of the Chinese caregiving tradition (Walker & Wong, 2005). Hsueh (2001) identifies four conceptual components of filial piety for children taking care of Chinese elders: 1) concern for parental health, 2) financially supporting parents, 3) fulfilling the housing needs of parents, and 4) respect for parental authority. Although material support constitutes an essential element of filial piety, emotional support and affection toward parents represent more significant values for Chinese elders (Chou, 2011). Children's behaviors and attitudes, according to filial piety values, should be "willingly and freely practiced, not as a result of authoritarian commands or coercion" from their parents (Cheung & Kwan, 2009, p.181).

Besides the actual caregiving behaviors, filial piety also governs the parent-centered caregiving moral values and the quality of its practice in China. In this sense, children's or even grandchildren's caregiving may be expected in the presence of filial piety morality (Cheung & Kwan, 2012). Social desirability may arise from and be reinforced by individuals' endorsement and practice of filial piety (Franks, Pierce, & Dwyer, 2003). This reinforcement may, in turn, enhance people's belief in and utilization of family caregiving instead of other types of long-term care (Cheung & Kwan, 2012). So the social desirability of filial piety may dampen the development of social support in long-term care for Chinese elders (Cheung & Kwan, 2012).

Therefore, filial piety is a family-centered cultural construction. Society expects children to sacrifice their own interests physically, financially, and socially for the welfare and well-being of their elderly parents (Dai & Dimond, 1998). It is a congenital, moral obligation. This brings lifelong reciprocity as the basis of filial piety: "Both generations believe that the creation of the children's physical existence and the care given them in childhood require children to reciprocate in their parents' old age" (Bain, Logan, & Bian, 1998, p.116). As a result, Chinese elders traditionally rely more on their children for family caregiving than elders in Western countries (Cheung & Kwan, 2009; Lai, 2007; Ikels, 2004).

Evolving filial piety. The concept of filial piety has evolved in urban China in recent years (Cheung & Kwan, 2009; Ikels, 2004). Urbanization in China has had a direct impact on the changes in the expression of family obligations (Whyte, 2004; Holroyd, 2003; Whyte, 1997). The Economic Reform, in particular, has contributed to declining moral standards of filial piety and to dissipating its practicality, because it introduces to the younger generation a new preoccupation with material advantage (Yu, 2013; Chou, 2011; Ikels, 2004). So filial piety has evolved to include options other than exclusive direct family caregiving (Ikels, 2004). For

example, children hired paid caregivers for elders in Shanghai (Wu et al., 2005).

Although Chinese moral values and caregiving traditions prescribe filial piety with accompanying law (Chou, 2011), these moral values and laws do not specify how to realistically implement filial piety to support the older generation. In the family caregiving context, children's awareness of filial piety and their availability to practice it have become questionable (Chou, 2011; Ikels, 2004). For example, Chou (2011) reports the emergence, content, legal foundation, and implementation of the Family Support Agreement policy in rural China to ensure parental support. It is a voluntary contract between generations on providing support to elderly parents (Chou, 2011). This contract explicitly stipulates children's filial obligation and caregiving responsibilities to their parents in order to protect the older generation as filial piety evolves under current socioeconomic circumstances. This policy formalizes children's caregiving responsibilities for their elderly parents, which used to be implicitly governed by filial piety. However, how potential intergenerational conflicts may emerge and how this contract can better implement filial piety in family caregiving remains unclear.

Filial piety and Chinese long-term care. Chinese health care and long-term care policy for elders is grounded in filial piety. Article 49 of the 1982 Constitution of the People's Republic of China stipulates that "parents have the duty to rear and educate their minor children, and adult children who have come of age have the duty to support and assist their parents" (Chen, 1996). The Law of Protection of the Rights and Interests of Elderly People of the People's Republic of China was enacted in 1996. This law stipulates that adult children are obligated to take care of the needs of their elderly parents. Article 11 specifically addresses that supporters should pay for the aged persons' living expenses, look after them and mentally comfort them, and give

consideration to their special requirements (National People's Congress of the People's Republic of China, 1996).

The Chinese government primarily relies on family caregiving and filial piety to meet the growing number of elders' needs for long-term care. The overall policy direction of long-term services development for Chinese elders has always been that "home care is the foundation, community-based care is necessary, and residential long-term care is supplementary" (Ministry of Civil Affairs, 2012, p.1). For example, the Shanghai municipal government proposed a "90-7-3 plan," which would mean that 90% of elders would need to be cared for at home, while 7% would make occasional visits to a community center, and 3% would live in nursing homes (Barboza, 2011). Heavy reliance on filial piety may skew the development of Chinese long-term care developments. Thus, how to incorporate the practice of filial piety into long-term care and balance the implications of urbanization for declining family caregiving for Chinese elders remains unanswered.

Filial piety and caregiving decision-making. Culture likely plays a critical role in shaping caregiving patterns. While all cultures more or less share dignity and respect for elders, the ways in which individuals make healthcare decisions and the values and beliefs guiding these decisions can vary considerably across cultural groups (Karel, 2007).

Filial piety cannot be underestimated in the caregiving decision-making for Chinese elders because of its strong cultural and moral implications. When violated (Kao & Stuijbergen, 1999), Chinese elders may view institutionalization as evidence of their children's abandonment (Tse, 2007). Although one qualitative study investigating nursing home residents' perspectives on filial piety in Shanghai found that these residents did not necessarily perceive being

institutionalized as a sign of their children's abandonment, filial piety still framed the decision-making processes (Chen, 2011).

As filial piety continues to evolve in contemporary Chinese society, elders may not be able to choose caregiving based on their personal preferences. Compared with their children, elders may have limited access to knowledge about long-term care services and insurance policies (if they have any) as well as limited resources to make such a decision. In this way, the balance of decision-making power may shift from the older to the younger generation. Adult children or key family members' preferences and their resources may have relatively greater power to influence the decision-making, despite it still taking place within a family context (Liu & Tinker, 2003).

Furthermore, filial piety influences the younger generation's caregiving burden and appraisals of caring for their parents (e.g., Chan, 2010; Lai, 2010; Cai, Giles, & Noels, 1998). Child caregivers' expressions of distress or need for help with caring for parents can trigger their own feelings of shame and failure (Zhan et al., 2008; Kim et al., 2006; Park et al., 2004; Yamamoto & Wallhagen, 1998). The younger generation must balance their (growing) desire for egalitarian, intergenerational relationships with their desire to conform to social desirability of filial piety (Zhang et al., 2005). This explains why placing their elderly relatives in a nursing home may not feel like an option to the younger generation and may cause additional caregiving stress (Zhan et al., 2008; Kim et al., 2006; Fitzgerald, Mullavey-O'Bryne, & Clemson, 2001). As such, filial piety remains omnipresent when adult children make caregiving decisions (Zhan et al., 2008; Kim et al., 2006; Park et al., 2004; Becker, Beyene, Newsom, & Mayen, 2003; Hinton, Fox, & Levkoff, 1999).

However, filial piety alone is often not sufficient for caregiving decision-making, especially when elders suffer from chronic illness. In fact, it may prevent seeking early interventions for social and physical support for elders as well as for family caregivers (Wykle, 2011). For example, female caregivers in Japan reported that they would turn to formal services after reaching the limit of their tolerance, a point at which they felt they could not continue caregiving under the given routines (Yamamoto & Wallhagen, 1998). Such stress may contribute to poorer health outcomes for elders, less children's financial stability, problems in interpersonal relationships, and potential intergenerational conflicts (Zhang et al., 2005; Zhang, 2004). Additional contextual factors, therefore, continue to be essential to long-term care decision-making.

Other relevant contextual factors. The decision to institutionalize in the United States often occurs when family caregivers have not yet depleted their caregiving resources (Karel, 2007; McLaughlin & Braun, 1998). However, a traditional Asian family may wait until the caregiving burden exceeds resources—even becomes a caregiving crisis—before seeking assistance and placement (Chang & Schneider, 2010; Kim et al., 2006; Hinton et al., 1999; McLaughlin & Braun, 1998). The cultural complexities underlying the varying psychosocial contexts may account for some differences between the United States and China.

In particular, the Economic Reform in urban China has had a tremendous influence on family caregiving contexts and people's conceptualization of caregiving (Chen, 2011; Zhan et al., 2008; Lee & Kwok, 2005; Ikels, 2004). The Reform has changed the nature of production, which has led to greater control of economic resources for the younger generation and less control for the older generation. This may have created a powerful new trend, shifting away from traditional family caregiving (Lee & Kwok, 2005; Williams, Mehta & Lin, 1999). Besides its implications

for the concept and practice of filial piety mentioned above, the Economic Reform has also influenced family caregiving in urban China in other ways, such as the growing aging population, declines in co-residence, changing gender roles in caregiving, and the reconstructed health insurance.

Aging population. Since the one-child policy took effect in 1978 (Zimmer & Kwong, 2003), China has experienced a drastic reduction in birth rates and a rapid increase in the aging population. Over 184 million people were over the age of 60 by the end of 2011 in China, accounting for 13.7% of the Chinese population, compared with 10.3% in the 2000 Census (Ministry of Civil Affairs, 2012). Among this 184 million, the number of elders aged over 65 was 123 million in 2011, accounting for 9.1% of Chinese population. In 2013, the aging population in China should exceed 200 million (Xinhua News, 2012).

Chinese population growth is projected to stabilize in 2030 when the size of the aging population may reach 240 million or 16% of the total population. By 2050, the aging population is predicted to be 450 million or 33% of the total population. The median age may then increase from 32.6 in 2005 to 44.8 in 2050, by which time the number of elders aged over 80 will have reached 100 million (China National Committee on Aging, 2009).

Furthermore, China has more than 33 million disabled or partially disabled elders aged 65 and over (Xinhua News, 2012). In 2006, China conducted the second national survey of the disabled population. Compared with the first survey in 1987, the number of disabled or partially disabled elders (60+) increased by 23.7 million. In 1987, the proportion of disabled elders (60+) was 21.9% of the total disabled population, while twenty years later, in 2006, the proportion increased to 53.2%. The total disabled aging population (60+) reached 44.2 million. If we include those over 65 only, the number is 37.5 million, accounting for 45.3% of the total disabled

aging population (Xie, 2008). The need for healthcare services for the growing number of Chinese elders will rise tremendously, especially for those who need help to carry out their daily activities (Wong & Leung, 2012). How to utilize long-term care to face increasing aging population and declining family caregiving is worth investigating.

Co-residence. The way that people live reflects characteristics and changes in demographics (Coleman & Garssen, 1996). Co-residence, namely, elders living with their adult children, operates as a proxy for elders to have access to unaccounted for/invisible sources of children's support (Giles, Wang, & Zhao, 2010).

As a result of the one-child policy and urbanization, Chinese elders' co-residence has undergone some major changes in recent years. Living alone among elders is one of the most significant examples: in 1994 the percentage was 7.67%; in 1999, it increased to 10.64%. In all, the overall increase was 38.72% over the five years (Sun, 2004). More recently, in 2005, a survey reported that 57% of elders were living with their children, down from 73% in 1982 (Herd, Hu, & Koen, 2010a). In urban areas, around 50% of elders live alone; in large cities in particular, this proportion has increased to over 70% (Xinhua News, 2012).

Children's decreasing availability for family caregiving and increasing geographical distances between parents and children also influence living alone among elders. First, the average family size in urban China decreased from 4.51 persons in 1982 to 3.58 persons in 1999, with a more than 20% decrease in this 17-year period (Sun, 2004). Consequently, the rate of co-residence among Chinese families has been slowly but steadily decreasing. The number of children available to provide family caregiving for elderly parents has decreased accordingly. Second, the geographical relationship between elderly parents and children affects children's ability to provide family caregiving. Distance may impede maintaining a close relationship

between children and parents (Chen, 2011; Kaufman & Uhlenberg, 1998).

In the United States, living alone represents the best predictor of institutionalization (Gaugler et al., 2009; Liu, Coughlin, & McBride, 1991). Although elders' living arrangements in the United States and China differ greatly in terms of the social, cultural, and familial contexts when disability levels increase and independence declines, elders who live alone may accept similar changes in caregiving arrangements—either having paid caregivers move in or moving out to children's homes or nursing homes. But the nuances of this process need further research.

Gender roles. The role of gender is another major contextual factor in the shift away from the tradition of family caregiving. Referring to the “loose interpretation” of filial piety (i.e., community care = family care = cared for by women; Chen, 1996), women undertake most of the care of elders in family caregiving. Chen (2011) found that daughters' availability for caregiving determined the family caregiving resources prior to institutionalization, which underscores the importance of women's provision of family caregiving and its potential relevance to elders' institutionalization. Furthermore, the decline in fertility, since the implementation of the one-child policy, implies that those who now are entering middle age have fewer siblings and fewer children than previous generations (Maurer-Fazio, Connelly, Lan, & Tang, 2009; Zhan et al., 2008). Fewer siblings and children suggest fewer family members share caregiving responsibility for elders.

From another perspective, if women drop out of the labor force to provide caregiving and, consequently, give up pension entitlements (i.e., retirement plans), they may find themselves substantially disadvantaged as they age (Maurer-Fazio, Connelly, Lan, & Tang, 2009). However, a quantitative analysis based on three Chinese population censuses (i.e., 1982, 1990, and 2000) found that living with older adults aged 75 and over increased the labor force participation rate of

married women by 2% and that having a co-residing parent or parent-in-law increased their participation by 4.6% in urban areas (Maurer-Fazio et al., 2009). This seemingly counterintuitive increase in women's labor force participation in urban China during their co-residence with elderly parents begs the question of what psychosocial factors drive them away from filial piety.

Reconstructed Chinese healthcare insurance. Since the Economic Reform, the Chinese government has limited government provision of healthcare in general. Before the Economic Reform, the primary Chinese healthcare insurance was of only two types: Government Insurance Scheme (GIS) and Labor Insurance Scheme (LIS; Dong, 2001).

From 1950 to 1980, GIS and LIS covered most of the urban population. They were a part of the overall government social welfare budget. Both plans covered 100% of healthcare expenditures (Dong, 2001). However, the government only provided both plans to urban areas, so the coverage was not nationwide. The entitlement was closely linked to recipients' employment and residential status of people. As a result, only 15% of the national population was entitled to both plans, while they had access to 60% of all healthcare resources (Leung, 2005). Until 1993, GIS and LIS covered approximately 9% and 40% of the urban areas or 2.5% and 11.7% of the total population, respectively (Dong, 2001).

Beginning in early 1980s, the Chinese central government reformed its economic and administrative system, including healthcare policy (Leung, 2005; Klein, 2003; Dong, 2001); it has recognized that it could no longer take sole responsibility for the provision of health care. This reform has taken the route of decentralization instead of relying solely on government funds. Work units are no longer expected to provide free public healthcare insurance (i.e., GIS and LIS). Government only pays for narrowly targeted disadvantaged groups, such as the mentally ill, the

impoverished, and “*three-Nos*” elders (i.e., no child, no income, and no spouse; Wong & Leung, 2012).

The restructured health insurance program has, thus, lowered the general coverage and depended more on individuals’ payments, though health services remain largely publicly provided (Herd, Hu, & Koen, 2010b). Despite a history of extreme collectivism, the Chinese government surprisingly advocates individualism in healthcare (Klein, 2003). About 92% of individual Chinese now have to pay privately for out-of-pocket health expenses (World Health Organization [WHO], 2010). The responsibility of individuals or of their families to meet at least part of their health care costs can be overwhelming. Compared with their American counterparts, Chinese elders have no national health insurance program (e.g., Medicare) and no public safety net program covering health and skilled nursing facilities (e.g., Medicaid; Feng et al., 2011b). Instead, they or their family members must pay for services themselves. The reconstructed health insurance leaves Chinese elders and their family caregivers very limited long-term care options, perhaps, only family caregiving. Other types of long-term care may need to consider the declines in the number of children and the provision of family caregiving.

In sum, the Economic Reform in China has influenced the concept and practice of filial piety, the growing aging population, the changes in co-residence, the transformation of gender roles in family caregiving, and the reconstruction of health care insurance. These contextual changes have fueled the question about whether the family alone will still be able to care for the fast growing aging population in urban China (Chen, 2011; Feng et al., 2011b; Chu & Chi, 2008; Flaherty et al., 2007). We need a holistic understanding of how these intertwined contextual factors may have affected families’ caregiving arrangements and the following caregiving decision-making in urban China.

Current Nursing Home Care in Urban China

Policy support. The Chinese government has made a series of legal and policy efforts to increase the number of nursing homes and to encourage good nursing home care quality (Chu & Chi, 2008; Flaherty et al., 2007). For example, the total number of nursing homes in urban China increased 13.26%, from 33,356 in 2003 to 37,782 in 2006 (Chu & Chi, 2008).

In 1998, the Chinese government enacted a regulation to allow society-run, non-collective units, including private enterprises, nongovernmental organizations (NGOs) and individuals, to invest in and operate nonprofit long-term care (Ministry of Civil Affairs, 2012; Wong & Leung, 2012). In 2001, the Ministry of Civil Affairs published *Standards of Social Welfare Institutions for the Elderly* (Wong & Leung, 2012). These guidelines attempt to standardize service quality and management practices, including staffing, premises, physical environment of the nursing home, and personal care services. These standards are applicable to nursing homes and institutions providing long-term care in all sectors (Wong & Leung, 2012).

In 2002, the Ministry of Labor and Social Security issued *Professional Standards of Caregiving for Older Persons* (Ministry of Labor and Social Security, 2002). This guideline regulates the detailed knowledge and skill requirements for the daily, medical, rehabilitation, and psychological care of elders receiving healthcare services in general. In addition, a job classification for different ranks of care workers has been proposed (Ministry of Labor and Social Security, 2002). In 2006, the State Council Information Office published a white paper titled *The Development of China's Undertakings for the Elderly* (China Web, 2006; National News Office of The People's Republic of China, 2006). "Nursing home development" is listed under the fourth initiative among the seven major "Social Services for an Aging Society" initiatives.

Current challenges. Major challenges to nursing home care development in urban China include inadequate provision with low quality and poor standards monitoring (Wong & Leung, 2012). The services in the nursing home care remain, in practice, unstandardized and unregulated (Chu & Chi, 2008). Currently, “nursing home care” in urban China would appear to be a poor catch-all phrase, that is, considerable variations in residents’ functional dependence and acuity levels exist across institutional facilities (Feng et al., 2011b; Flaherty et al., 2007). This situation may be similar to that in nursing homes in the 1960s or 1970s in the United States, when a post-acute industry had not yet developed (Feng et al., 2011b; Stone, 2000). Moreover, the Ministry of Civil Affairs has not released any explicit quality standard, code of practice, or practice guideline applying to the services offered in nursing homes (Chu & Chi, 2008). The compliance and monitoring of service quality in nursing home care and other community-based long-term care remain difficult and insufficient.

Similar to the United States, the lack of training among nursing home staff poses another challenge to the development of nursing home care in urban China. Almost all existing nursing homes in China provide only basic healthcare, without any trained social workers (Feng et al., 2011b). In general, the staff in nursing homes can be classified as administrative staff and frontline workers (i.e., personal care staff; Chu & Chi, 2008). Administrative staff usually has only a general educational background but no specialized training in social work, nursing, geriatrics or other related fields (Tung, 2006). The major sources of frontline workers are laid-off workers in previously state-run factories in urban areas and migrant workers from rural China (Chu & Chi, 2008). They often do not have any training in geriatric care (Tung, 2006). High staff turnover rate additionally impedes the training and care in the nursing home, due to low social status and pay, different language (i.e., dialects) and customs, and demanding workload (Chu &

Chi, 2008; Tung, 2006). The turnover rate of their counterparts in the United State was also high, at 39.5% in 2010 (American Health Care Association [AHCA], 2011). As a result, China requires at least 10 million trained workers to provide care for elders and currently only a small proportion of people working in the field is competent (Ministry of Civil Affairs, 2012).

Yet another factor, financial issues, impede the development and acceptance of nursing home care in urban China. The majority of nursing homes still heavily rely on local government for financial support. Nursing homes operated by government organizations usually attract more elders due to low fees (Feng et al., 2011b; Zhan et al., 2008). The burgeoning private nursing homes remain vulnerable to uncertainties over income and governmental support. They usually charge much higher fees than government-sponsored ones to ensure their daily operation. However, the high fees hamper their popularity in the aging population. Moreover, the low quality of care in private nursing homes raises questions, especially when compared with government-sponsored ones. Many of the private nursing homes lack facilities, personnel, and professional support (China News, 2012). A recent survey reveals considerable variations in the types of nursing homes in Nanjing, such as government, private, and hospital-affiliated as well as a lack of standards in financing, staffing, and caregiving services (Feng et al., 2011b).

A potentially high prevalence of Alzheimer's disease and other dementias represents another significant challenge for the future development of nursing home care in urban China. Unlike their counterparts in the United States, more nursing home residents in China are cognitively-intact. For example, a recent survey in Nanjing found that only 23% of residents had dementia (Feng et al., 2011b), which is in contrast to an estimated 50%-70% rate of dementia among nursing home residents in the United States (Miller, Lima, & Mitchell, 2010). However, in reality, approximately 9.2 million Chinese elders have Alzheimer's disease and other

dementias (MacKenzie, 2013) with an annual 4.8% increasing rate (i.e., about one million each year; Li, 2011). China's prevalence exceeds the 5 million national estimate of Alzheimer's disease prevalence in the United States (Alzheimer's Association, 2013; Brookmeyer et al., 2011). At the same time, more than 300 Alzheimer's disease centers provide diagnosis, treatment, rehabilitation, and daycare in the United States (Miller et al., 2010). China has none. Thus, most Chinese elders suffering from Alzheimer's and other dementias do not have any access to community-based support (Li, 2011).

Thus, although the Chinese government supports the development of nursing home care, various challenges have made nursing home care in urban China remain operating at a nascent stage. The current rapidly growing utilization of nursing home care among elders in urban China requires a deeper understanding of relevant psychosocial contexts (Feng et al., 2011b).

Research Gaps in Deciding to Institutionalize

A large body of evidence investigating predictors of elders' institutionalization exists in Western gerontology, social welfare, and public health literatures (e.g. Wattmo, Wallin, Londos, & Minthon, 2011; McLennon et al., 2010; Byrne et al., 2009; Gaugler et al., 2009; Martikainen et al., 2009; Kane, Bershadsky, & Bershadsky, 2006; Gaugler, et al., 2003; Forbes & Hoffart, 1998; Levy-Storms, 1996). For example, increase in age, decline in ADLs or IADLs, living alone, the diagnosis of dementia, and incontinence all relate to nursing home admission across Europe and the United States (Wattmo et al., 2011; Luppá, Luck, Watschinger, König, & Riedel-Heller, 2010; Gaugler et al., 2009; Martikainen et al., Gaugler et al., 2003).

However, these predictors may not convey the psychosocial contexts of the decision to institutionalize. For example, discrepancies between children's open-ended interviews and

questionnaire answers exist in the reasons to decide to institutionalize their elderly parents (Cohen-Mansfield & Wirtz, 2009). Children report deterioration of independence and confusion as the primary reasons to institutionalize their elderly parents, while regression analyses reveal depression and the diagnosis of dementia as statistically significant predictors for these elders' institutionalization, in addition to the expected deterioration of independence. Different research methods reveal children's divergent reasons for deciding to institutionalize their elderly parents, so their psychosocial mechanisms need further research (Cohen-Mansfield & Wirtz, 2009).

Still, investigating a single generation may seem inadequate. Most research evidence on deciding to institutionalize investigate generations separately, which may distort underlying meanings during the process. Understandably, because of cognitive deterioration of 48.1% of nursing home residents in the United States (Miller et al., 2010), many studies focus on child caregivers or the younger generation (e.g., Chang & Schneider, 2010; McLennon et al., 2010; Cohen-Mansfield & Wirtz, 2009).

In contrast, limited research evidence investigates elders' perspectives on institutionalization, which may be due to their declining cognition. But for cognitively-intact elders, their opinion deserves attention. For example, a qualitative study investigated cognitively-intact African American and European American elderly residents about their institutionalization (Johnson, Popejoy, & Radina, 2010). However, only two themes emerged as "They put me in here" and "I/we made the decision" (Johnson et al., 2010), which seems to oversimplify the decision-making dynamics between generations. Each generation may present a different perspective on institutionalization, and input from both is needed in the same study. Such examinations may reveal how broad cultural shifts (i.e., modernization and globalization) may materialize in interpersonal behaviors at an individual level (Zhang et al., 2005).

Another reason for possibly missing intergenerational communication in previous research is that the process is infrequently examined with theoretical constructs, despite an increase in published literature focusing on this issue (e.g., Chen, 2011; Chang & Schneider, 2010; Zhan et al., 2008; Liu & Tinker, 2003; Kao & Stuijbergen, 1999). These studies have not used consistent theories or theoretical constructs, thus, making this body of studies potentially less valid in explaining or conceptualizing how intergenerational communication occurs during the decision-making process around institutionalization.

In terms of research methodology, qualitative methods allow one to develop a complex understanding of the psychosocial and contextual factors behind individuals' decisions to seek caregiving support (Bradley, Curry, & Devers, 2007). Chang and Schneider (2010) employ a grounded theory method to interview 30 child caregivers in Taiwan about deciding to institutionalize their elderly parents with dementia. The study categorizes the decision-making into four stages: initiation, assessment of decisions, finalization of decisions, and evaluation of final decision. The first stage is to initiate the placement decision, especially when child caregivers notice their parents' deteriorating health and dementia-related behaviors, their own worsening health conditions, and negative impact on family relationships. Child caregivers begin to seek professional assistance. The second stage is to assess the decision. In this stage, the child caregivers gather and compare information about different caregiving options and negotiate with family members about these options. The third stage is to finalize the decision and help their parents move into a nursing home, which can be consensual, partially consensual, or reluctant between child caregivers and their parents. The last stage entails evaluating the decision, including visiting parents frequently in the nursing home, adjusting children's own expectations of nursing homes, and reconciling family relationships.

Chen (2011) carried out semi-structured interviews to investigate 11 cognitively-intact nursing home residents' perspectives on institutionalization in Shanghai. Her findings suggest negotiations between generations on caregiving options prior to elders' institutionalization. Children proposed alternatives to nursing homes, such as hiring a paid caregiver and/or moving in with children. However, participating elders reported that they voluntarily chose to institutionalize, rather than seeing it as a violation of filial piety or abandonment by their children. These participants emphasized the socioeconomic changes in Chinese society, which have made more caregiving options available.

A major limitation of Chen's (2011) study results from the lack of the children's perspectives. Children's perspectives surely contribute to understanding the dynamics of intergenerational communication in deciding to institutionalize, including such factors as the content, the frequency, and the hierarchy of communication. For example, the underlying dynamic in intergenerational communication may be linked to the younger generation's increasing desire for egalitarian status (Zhang et al., 2005). It is critical to investigate how children's perspectives on caregiving may help or hinder intergenerational communication on caregiving arrangements, which eventually leads to the decision to institutionalize.

Another limitation of Chen's (2011) study concerns the lack of deeper understanding of the positive responses from participants, who reported that they benefitted from social networks and support in the nursing home. However, nursing home residents in two Hong Kong studies (Cheng, 2009; Tse, 2007) associated institutionalization with shame and disappointment in their children's filial attitudes. The contradictory findings in Shanghai and Hong Kong require a more holistic examination of elders' perspectives on nursing home care in the current study.

Consequently, one must learn from both generations about the family caregiving context, the series of events, and intergenerational communication when they decide to institutionalize. So adding children's perspectives is essential to have a holistic understanding of both generations' experiences of deciding to institutionalize. It may also provide much value for exploring the implications of the Economic Reform on the evolving concept of filial piety and caregiving arrangements in urban China.

In terms of analyzing health service utilization, the Andersen Behavioral Model has continued to be a predominant theoretical framework (Andersen, 2008; Afilalo et al., 2004; Andersen, 1995). However, this theoretical framework may better answer the questions about whether individuals *ever* use services than about *why* they use services and *how* they decide to utilize certain kinds of services. This model may be better at quantitatively measuring “help-getting” than “help-seeking” (Pescosolido & Boyer, 1999). However, this framework has been expanded to conceptualize qualitative inquiries in healthcare service utilization (e.g., Bradley et al., 2007; Bradley et al., 2002). The expanded Andersen Behavioral Model has found that psychosocial determinants affect the way people utilize healthcare service (Bradley et al., 2002; Andersen, 1995). Thus, qualitative methods are highly relevant for examining the psychosocial contexts of the decision to institutionalize among elders and their adult children.

However, this qualitative exploration needs theoretical support. The next chapter will review relevant theories to conceptualize the experiences of deciding to institutionalize.

CHAPTER III

Theories and Propositions

The purpose of this chapter is to review several theories relevant to deciding to institutionalize. First, it will introduce crisis theory and how family caregiving crises may initiate the decision to institutionalize. Second, it will define intergenerational communication and identify its potential impacts on deciding to institutionalize. Third, it will discuss uncertainty management theory (UMT) to understand how each generation conceptualizes and manages the potential uncertainties of institutionalization.

This theoretical review identifies three preliminary sensitizing propositions⁵ as a starting point for developing interview guides for each generation. A tentative conceptual framework is proposed to illustrate intergenerational communication and the decision-making process around institutionalization between generations.

Crisis Theory

Proposition 1: Family caregiving crises initiate the decision-making process around institutionalization among elders and their children.

No consistent definition of a “family caregiving crisis” exists; it is relative to a family’s caregiving resources. Some have referred to a caregiving crisis as being temporary, having a sudden onset, and evoking emotional and instrumental caregiving tensions that need to be resolved (Sprangers, Tempelaar, van den Heuvel, & de Haes, 2002). Others have emphasized that a wide range of family caregiving crises occur when taking care of sick parents, not only health or caregiving related, but also social, emotional, financial, and idiosyncratic to a family (Sims-Gould, Martin-Matthews, & Gignac, 2008).

⁵ Sensitizing propositions here mean qualitative postulates.

According to crisis theory, any changes may induce a potential caregiving crisis, which requires restructuring of family caregiving patterns (Schulz, Gallagher-Thompson, Haley, & Czaja, 2000; Levy-Storms, 1996; Biegel & Blum, 1990). Crisis theory defines two main types of changes, maturational and situational, which can cause family caregiving disequilibrium (Schulz et al., 2000). *Maturational* changes pertain to people's normal development stages, usually occurring at major life transitions, such as childbirth, children leaving home, and retirement. *Situational* changes pertain to unpredictable crises, for example, the illness of elderly parents. Both maturational and situational changes may lead to family caregiving crises, but the latter is of more concern for family caregiving for elders with chronic diseases. Various situational changes result from the suddenness of illness onset, which, if grave enough, may lead to family caregiving crises, such as a fall, a stroke, or a potentially terminal diagnosis, such as cancer and dementia (Biegel, Sales, & Schulze, 1991). These sudden onset changes may not predict elders' immediate institutionalization, but rather relate to the declines in family caregiving resources, the changes in caregiving arrangements, and the stressed caregiving relationships, which possibly lead to elders' institutionalization (Levy-Storms, 1996).

Although both generations' perceptions of a caregiving crisis may differ, and the stress caused by these crises may vary, a caregiving crisis may have more or less additional costs to children. Besides substantial opportunity costs in terms of children's working time and income (Scharlach et al., 2006), constantly providing care can be psychologically burdensome for them (Hoving et al., 2010). They may tolerate high levels of stress to provide emotional support for sick parents and to confront their own initial fears in terms of overwhelming caregiving responsibilities (Schulz et al., 2000). Consequently, a caregiving crisis may further affect caregiving relationships, which disrupts the ongoing family caregiving for *both* generations.

Thus, for the purpose of this study, a caregiving crisis may occur with any changes in caregiving resources, arrangements, and/or caregiving relationships. Specifically, it may relate to declining family caregivers' abilities and depleting family caregiving resources to respond to elders' increasing caregiving needs. The caregiving crisis, then, may motivate either generation to reestablish the caregiving equilibrium and initiate the decision-making process around institutionalization.

Intergenerational Communication

Proposition 2: In intergenerational communication, each generation favors maintaining positive social identity and decision-making capacity.

Aging is socially constructed (Williams & Nussbaum, 2001). Over the life course, people tend to transition more from being labeled "young" to being labeled "old," in contrast to other demographic categories, such as gender or ethnicity (Barker, Giles, & Harwood, 2004). Consequently, younger people and older people recognize themselves as members of different groups based on age differences, namely, generational differences. The generational culture and identity that people acquire stem from these perceived differences and their inclination to make comparisons with other age groups (Barker et al., 2004). For example, the younger generation may recognize the age advantages of their generation, such as higher education, and may neglect the advantages of the older generation, such as life experiences and wisdom.

Social identity theory (SIT) can help to explain the positive social identity that people achieve by comparing themselves with other groups. SIT defines an individual's self-concept as consisting of two parts: personal identity and social identity (Tajfel & Turner, 1986). Personal identity emphasizes an individual's personal characteristics, such as likes and dislikes. Social

identity, however, is one's identity as a member of various social groups. Thus, social identity consists of various group classifications and constructs of people's self-image, based on the social and psychological categories in which they perceive themselves as belonging (Tajfel & Turner, 1986).

SIT posits that individuals innately categorize themselves and others as members of groups. By comparing their group position with that of others, they try to achieve a sense of positive identity (Barker et al., 2004; Tajfel, 1978). According to SIT, attempts to achieve positive social identity often result in discrimination, favoring members within the group and resulting in a negative identity for members outside the group. For example, the younger generation may perceive themselves as having more positive identities than the older generation, since they may own more social and economic resources. This implies that some potential intergroup conflicts may exist between generations.

More important to this study, social identity manifests in communicative behaviors, especially the linguistic strategies distinguishing members from other social groups (Barker et al., 2004). Hajeck and Giles (2003) define intergroup communication as "any communicative behaviors exhibited by individuals toward others...based on the individuals' identification of themselves and others as belonging to different social categories" (pp. 140-141). Thus, in this study, intergenerational communication is defined as the ways in which Chinese baby boomers and their parents communicate to decide to institutionalize, including perceptual, strategic lingual underpinnings of their communication.

Intergenerational communication involves a range of features of verbal and nonverbal behaviors (e.g., name or titles used, vocabulary, formality, and tone of voice; Janssen & MacLeod, 2010), emphasizes the individual generation's interests, and has reciprocal impacts on

each generation (Williams & Nussbaum, 2001). Individuals of different generations may seem to share the same society, but they actually live in different cultural spaces (Barker et al., 2004; Williams & Nussbaum, 2001). For example, although elders and their children have both experienced the Economic Reform in urban China, two generations may still have different perspectives on the resulting social developments resulting from different psychosocial experiences. In urban China, conflicts in intergenerational communication may become more obvious. The traditional value of filial piety legitimizes the positive identity of elderly parents in relation to their children and validates parents' positive social identity. However, their children may view themselves as having greater decision-making capacity and stronger social identity, since they may be more adapted to the evolving social contexts and own more caregiving resources (Zhang et al., 2005). Indeed, it is difficult to establish "equal power" (i.e., not related to age differences) between generations, because elderly parents do not have an experiential advantage in deciding to institutionalize (Fox & Giles, 1993).

As such, intergenerational communication may potentially lead to misunderstanding and miscommunication, due to the chronological distance, different communication styles between generations, and ageism on the part of the younger generation (Williams & Nussbaum, 2001). In other words, intergenerational contact is often tainted by age-based prejudice (Soliz & Harwood, 2003). For example, miscommunication or misunderstanding often occur between elders and their children when they make caregiving decisions together, because the younger generation may believe their elderly parents have limited experiences or capacities to make the decision (Giles, Ryan, & Anas, 2008; Chen & King, 2002; Bethea & Baleazs, 1997). These negative assumptions about their parents' abilities may lead the younger generation to use patronizing

communicative behaviors such as oversimplified speech, baby talk, or just ignoring (Ryan, Hummert, & Boich, 1995).

In addition, power relations exist in intergenerational communication (Barker et al., 2004; Coleman, 1990). Power refers to a person's ability to influence another person's thoughts or behaviors, and the resistance to these attempts by the other person (Pecchioni, Wright, & Nussbaum, 2005). Throughout the life course, people take on different family roles, and these roles possess different levels of power within the relationships among family members (Elder et al., 2003). For example, parents control a number of resources when their children are younger, such as money, affection, and material possessions, and they may use these to try to influence their children's behaviors and decisions. But as parents age, greater control of economic resources by the younger generation compared to the older generation may lead to a shift away from traditional family caregiving in Asian countries (Lee & Kwok, 2005; Ikels, 2004; Williams, Mehta, & Lin, 1999).

As such, despite their parents' growing age, the Chinese baby boomer generation may endorse their parents' age-based status less, and their parents may have to adapt to new caregiving expectations based on the interests of their children (Lin & Zhang, 2008). For instance, increased freedom of choice in job selection and locations, negotiations in living arrangement between generations, and changes in paying for health care costs have been to the advantage of children and to the disadvantage of elderly parents. In particular, with the changes of roles in the family, the power of influencing decision-making also changes. As parents age, the distribution of decision-making power may change: adult children may be more involved in decision-making with their parents or even make some decisions for their parents (Moye & Marson, 2007; Smyer, 2007; Pecchioni et al., 2005). So this study focuses on how both

generations communicate to achieve positive identity and to have greater capacity when deciding to institutionalize between elderly parents and their children in urban China.

Uncertainty Management Theory

Proposition 3: In making the decision to institutionalize, each generation may conceptualize the caregiving uncertainties related to the decision differently, and the conceptualization entails material and emotional dimensions. Intergenerational communication may influence the management process.

Uncertainty management theory (UMT) originated from a need to understand communication processes in the management of illness or healthcare-related uncertainty (Hogan & Brashers, 2009). Hogan and Brashers (2009) classify three forms of uncertainty in healthcare: medical, personal, and social. The first form of uncertainty is *medical*. For example, insufficient information and unpredictability of a disease's progress or its treatment procedures can engender uncertainty. The second form of uncertainty is *personal*. For example, unclear financial consequences can cause uncertainty. The third form of uncertainty is *social*. For example, uncertainty may come from the unpredictable and conflicting caregiving relations. At a fundamental level, UMT offers a way to sort through the relationships that exist between the experience of uncertainty and information exchanges (Hogan & Brashers, 2009).

UMT categorizes the uncertainty management process into information seeking, appraisal, adaptation, and reappraisal (Hogan & Brashers, 2009). If both generations consider entering a nursing home as a potential solution for the family caregiving crisis, they may collect the information about eligible nursing homes, staffing, meal services, and exercise routines. By comparing and contrasting the uncertainties pertaining to each eligible nursing home and to what

degree they can manage these uncertainties, older adults and their children evaluate these nursing homes until they find a relatively suitable one. UMT helps to describe how Chinese child caregivers continuously evaluated the decision after their parents entered a nursing home (e.g., Chang & Schneider, 2010), the caregivers' experiences and ambiguous feelings about their parents entering a nursing home (e.g., Ryan & Scullion, 2000), and how both generations balanced conflicting preferences in caregiving patterns (e.g., Whitlatch, 2008).

In particular, UMT emphasizes the importance of comparing and prioritizing these uncertainties by communication. People need to emotionally prepare for the uncertainty, due to the stress along with any changes in caregiving. For example, older adults may need to cope with the anxiety or fear when facing the potential uncertainty about their diagnoses, their life adjustment, and their relationship with children after entering a nursing home. Children may consider potential worse health conditions of parents and pressure from the traditional caregiving culture after institutionalizing their parents. Chappell (2008) used UMT to compare the caregiving offered by family (e.g., spouses and children) with paid caregivers among elders in Shanghai by examining intergenerational communication and emotional exchanges in their communication.

Uncertainty management is closely connected with decision-making (Scholz, 1983). It is critical to know how both generations conceptualize the uncertainties pertinent to entering a nursing home and how they communicate about the issue with each other in light of each generation's interests. In the context of uncertainty, decisions are defined by the level of incomplete information or knowledge about a situation, such as the possible alternatives, the probability of their occurrence, or the degree to which outcomes are known (Scholz, 1983). Uncertainty may be internally attributed (e.g., elders are not sure whether they can benefit more

from a nursing home than family caregiving) or externally attributed (e.g., it is not clear whether entering a nursing home can reduce the caregiving stress for children; Scholz, 1983). By clarifying uncertainties in intergenerational communication, both generations may set certain criteria for selecting a nursing home, in an effort to manage those uncertainties and to make a final decision. Chen (2011) found that child caregivers transferred their worries or concerns into selection criteria for a qualified nursing home, such as if the nursing home provides special meals for residents with diabetes *based on interviews with elders*.

Therefore, UMT can help to analyze intergenerational communication to understand how elders and their children handle the uncertainties of changes in caregiving routines, how they appraise and reappraise the uncertainties of nursing home care, how they cope with the related emotional disturbances, and how they transfer these uncertainties into selection criteria for nursing homes.

Conceptual Framework

Table 2 summarizes the three propositions outlined above, drawing on crisis theory, the definition of intergenerational communication, and UMT to help conceptualize the decision to institutionalize among elders and their children in Shanghai. The three prior propositions predispose potential self-biases in this study and provide direction for the study but do not determine outcomes (Gilgun & Abrams, 2002). They will be modified according to interpretations of participants' responses in the interviews. The comparison⁶ of these propositions before and after the study will appear in the discussion in Chapter VI.

⁶ This comparison is not necessarily a standard in qualitative research, but rather, one way to acknowledge the inherent subjectivity in it for this study.

Table 2

Three Preliminary Propositions

| Proposition | Theory | Before the Study | After the Study |
|--------------------|---------------------------------|--|------------------------|
| 1 | Crisis Theory | Caregiving crises may initiate the decision-making process around institutionalization between generations. | |
| 2 | Intergenerational Communication | The younger generation may have greater capacity to make the decision. | |
| 3 | UMT | Each generation may conceptualize caregiving uncertainties differently related to the decision to institutionalize, and intergenerational communication influences the management process. | |

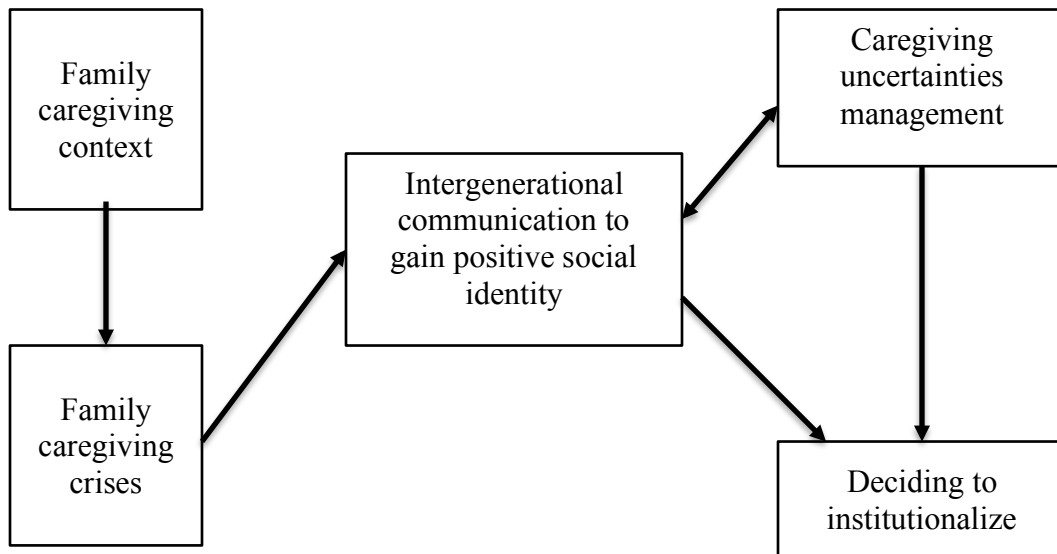


Figure 2. Conceptual framework of deciding to institutionalize.

Figure 2 conceptualizes the decision-making process around institutionalization among elders and their children in Shanghai. The decision to institutionalize begins with one or more changes in family caregiving and depleting caregiving resources, which may initiate intergenerational communication.⁷ However, each generation wishes to gain positive social identity and in the end to maintain decision-making capacity by comparing itself with the other.⁸ When each generation conceptualizes the decision to enter a nursing home, they need to consider and manage the uncertainties related to the decision.⁹ Meanwhile, intergenerational communication conveys opinions and concerns from each side, in order to continually manage the uncertainties.¹⁰ As the decision-making progresses, intergenerational communication may continue to take place and to influence uncertainty management.

This theoretical review conceptualizes the decision to institutionalize among nursing home residents and their children in Shanghai. Although this conceptual framework has not been used in Chinese populations, each individual theory has been applied to either Chinese or Taiwanese populations. So this framework can be applied to participants from Shanghai.

The conceptual framework is to guide the phenomenological approach of this study. The next chapter will discuss phenomenological methodology in detail.

⁷ Proposition 1

⁸ Proposition 2

⁹ Proposition 3

¹⁰ Proposition 3

CHAPTER IV

Research Methodology

This chapter describes the phenomenological approach in this study. First, it will illustrate the research purpose, study design, and rationales. Then, it will describe the study procedures.

Research Purpose

The purpose of this study is to understand the decision to institutionalize among nursing home residents and their children in Shanghai. Intergenerational communication about this decision will be explored. The main research question is: How did nursing home residents and their children decide to institutionalize in Shanghai? A related sub-question is: What were the psychosocial contexts involved in making this decision among these nursing home residents and their children in Shanghai?

Study Design and Rationale

Study design overview. This research is a qualitative study. Qualitative inquiry seeks to understand the experiences and perceptions of people who are part of the phenomenon of interest (Patton, 2002). Its underlying assumption is that a phenomenon can best be understood as viewed by those who experience it (Patton, 2002). Researchers understand the phenomenon of interest by understanding how individuals define and live in this phenomenon, which is constructed by their beliefs, values, and cultures. Especially in healthcare, qualitative methodologies can generate rich information, including but not limited to patient preferences; culturally determined values; and health beliefs, health-seeking behaviors, and health disparities (Bradley et al., 2007).

Specifically, this study takes a descriptive phenomenological approach to understanding the decision to institutionalize among nursing home residents and their children by investigating intergenerational communication. A phenomenological study describes the meaning of the lived experiences for individuals about a phenomenon (Creswell, 2007). The purpose of a phenomenological study is to explore the structures of consciousness in human experiences (Creswell, 2007). This study aims to recognize the meaning of deciding to institutionalize among elders and their children in Shanghai.

Descriptive phenomenological research investigates experiences to obtain holistic descriptions, which then provide the basis for a reflective analysis to capture the essences of these experiences (Moustakas, 1994). Phenomenology assumes: “There is an essence or essences to shared experience” (Patton, 2002, p.70). These essences are the core meanings shared by those who have had similar experiences.

The procedures of a phenomenological study include reading the original data, consisting of crude descriptions obtained through open-ended questions and dialogue, and describing the structure of the experience based on participants’ reflection and interpretation of their stories (Creswell, 2007). The final report of a phenomenological study brings an essence of the experience of interest and recognizes a unifying meaning of the experience (Creswell, 2007).

Qualitative inquiry. Given the complexity of the changes occurring in individuals’ lives, qualitative inquiry is more appropriate to capture the nuances of their experiences than quantitative inquiry. For example, the multilevel processes linked by aging yield a complex of cross-level relations and temporal-historical contingencies (O’Rand, 1996). Qualitative research can also identify the contextual nature of variations in human behaviors (Kagawa-Singer, 2010). In particular, the dynamic nature of caregiving pattern changes is a nonlinear process, which is

hard for quantitative inquiries to construct models to predict (Levy-Storms, 1996). Specific to this study, a quantitative approach on intergeneration relationship may mask its phenomenological, qualitative aspects (Clarke, Preston, Raksin, & Bengtson, 1999). In addition, qualitative inquiry is a culturally and linguistically appropriate way to examine the nuances in intergenerational communication (Tanjastiri et al., 2007). So, unlike quantitative studies with random sampling procedures based on statistical probability and generalizability, the objective of this study is to describe in-depth, context-based experiences. The applicability of this study, then, is to theory instead of a larger population (Creswell, 2007; Lincoln & Guba, 1985). Thus, qualitative inquiry may arguably be more critical and meaningful for this study.

The utilization of a conceptual framework indicates that both inductive and deductive paradigms can contribute to the qualitative research. Patton (2002) argues that qualitative research can adopt both paradigms, which essentially make up a circular process to inform each other and to complete the research from both broad and specific aspects (Kagawa-Singer, 2010).

While the inductive paradigm reveals major patterns and indicates that researchers are open to whatever emerges from the qualitative data, the deductive paradigm can verify and elucidate the pattern that appears to be emerging (Hyde, 2000). In this study, the conceptual framework, as the deductive paradigm, helps to develop the interview guides¹¹ and to verify emerging patterns from interviews. It integrates core elements of the three theories illustrated in Chapter III. It can be informative in sensitizing postulates in the interviews.

However, all social scientists, implicitly or explicitly, attribute a point of view and interpretations to the people whose actions they analyze (Becker, 1996). The conceptual framework may lead to theory-laden observations. That is, researchers are inclined to look for observations that support their theories (Benton & Craib, 2001). But the findings that qualitative

¹¹ See Appendix A and Appendix B.

methods produce are indeterminate and subject to modification under different situations (Gilgun & Abrams, 2002). The author was cautious about such theory-laden observations and tried to minimize theoretically biased judgments during the interviews. She foresaw potential changes in the conceptual framework and propositions after the interview and left a blank column labeled “after the interview” in Table 2 in Chapter III.

Phenomenological approach. Phenomenology has its roots in the “philosophical perspectives” of German mathematician Edmund Husserl (1859-1938) and has been used extensively in the social and human sciences including sociology, psychology, nursing/health sciences, and education (Creswell, 2007; Moustakas, 1994; Farber, 1943). What appears in consciousness is a phenomenon, providing the impetus for experience and for generating new knowledge (Moustakas, 1994). In other words, what is important for a phenomenological study is to know what people experience and how they interpret these experiences. In particular, this study follows Husserl’s descriptive phenomenological approach, which emphasizes intentionality, phenomenology reduction, and the essence of an experience.

Intentionality. Intentionality refers to “the power of minds to be about, to represent, or to stand for, things, properties and states of affairs” (Jacob, 2010). A phenomenological study emphasizes “the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image and meaning” (Creswell, 2007, p.59). Intentionality becomes the means of constituting meanings, shaping sensibility, and conceptualizing cultural experiences, in which individuals construct their world, beliefs, and values, and these experiences and meanings intertwine constantly (Biehl, Good, & Kleinman, 2007). Human beings have an ensemble of ways to perceive, affect, think, desire, fear, and so forth—all part of the animation of acting intentionally (Ortner, 2005).

In discussing the “intentionality” of consciousness, Husserl argues that human consciousness actively consists of intentional objects (Holstein & Gubrium, 1994), which appear in people’s reflection—people have thought of these objects, perceived them, and so forth—and become phenomena (Wagner, 1970). Every experience is, thus, not only characterized by the fact that it is a consciousness, but also simultaneously determined by these intentional objects constructing consciousness. In other words, these intentional objects construct people’s world and experiences in their consciousness, and at the same time, they become facts. When they become facts, people accept these intentional objects as unquestionable. As Husserl says, “from the natural standpoint,” people accept as unquestionable the world of facts that surrounds them as existence out there in everyday life (Wagner, 1970). However, when people begin to question the existing world, the intentional objects that people used to understand no longer make sense to them. Then people are likely to suspend comprehending these intentional objects and all the actions toward them. Thus, these intentional objects are not meaningful to people any more.

Then what remains? Husserl points out that the remaining world for people becomes the concrete entirety of streams of their experience containing all their perceptions and reflections, in short, their consciousness (Wagner, 1970). Such consciousness continues to be intentional, as consciousness continues to exist in people’s minds. This “inward consciousness” constructs phenomena in people’s minds, which appears as reflections, interpretations, and meanings. This process is phenomenological reduction. Phenomenological reduction, thus, makes accessible the stream of consciousness in itself “as a realm of its own in its absolute uniqueness of nature” (Wagner, 1970, p. 59). Phenomenological reduction, namely, the epoché, will be discussed later in this section.

This phenomenological reduction is important for phenomenological methodology not only because it reveals the stream of consciousness in its pure form as much as possible, but also because it makes the structures of consciousness visible (Wagner, 1970). When people begin to question their everyday life, they tend to reflect or interpret their experiences, and they distinguish these experiences from their current living. The experiences are apprehended, perceived, and marked out of other experiences that people are living through. The reason these experiences stand out from others is because people pay special attention to them (Wagner, 1970). When people turn their attention to these experiences, they begin to reflect on them and make sense of them, during which they are no longer purely living through them. Thus, these experiences become meaningful to people.

Once an experience becomes meaningful, it is a past experience, that is, it is presented from a retrospective glance, and considered as already finished and done with (Wagner, 1970). Then people are able to apprehend, reflect, interpret, and even compare such an experience with their current living to make judgments. Therefore, only the already experienced is meaningful, not that which is being experienced (Wagner, 1970).

Intentionality typifies social phenomena. Taking people's intentionality into account, researchers argue for treating social phenomena as distinct from other phenomena, based mainly on the concern that social facts are structurally different from natural facts. Actually, social facts are imbued with interpretations and values (Searle, 1991). Intentionality is thus one of the most distinguishing characteristics of social phenomena.

Intentionality actually constructs realities (Prasad, 2005). These reflections, interpretations, and meanings of experiences are considered real (Holstein & Gubrium, 1994). No reality is considered more "true" than any other, though social actors may be more or less

well informed within the context of their lives (Prasad, 2005). Schutz argues that people tend to use common sense, namely, intentionality, to typify objects, emotions, and behaviors in order to produce a familiar world—a process of *typification* (Holstein & Gubrium, 1994). As the process continues, people's consciousness makes finer distinctions with different typifications, and continues to develop based on new observations or experiences. Eventually, people build up typifications of typifications to construct the society and the world.

Phenomenology of the society is based on how people build up typifications of other people, classifying them into types with particular qualities from whom typical courses of action can be expected (Benton & Craib, 2001). That is, people assume that those who share similar experience are likely to share similar understanding as well. This gives people commonsense, taken-for-granted knowledge about the society that guides people's actions from day to day. Thus, the society is built up from a complex of typifications, a taken-for-granted stock of knowledge that people share with others (Benton & Craib, 2001).

A phenomenological study attempts to gain insights into the role of intentionality in how people meaningfully construct experiences, how these experiences make sense to people in the phenomenon of interest, and how taken-for-granted meanings alter people's experiences. Researchers of phenomenological studies gain insights by interacting with study participants (Secombe, James, & Waltersset, 1998). In other words, the meanings of the people's behaviors and thoughts can only be discovered through interactions between the researcher and participants (Benton & Craib, 2001).

Phenomenological reduction. Phenomenological reduction is the means for examining intentionality of consciousness. In this way, participants' natural attitudes can be recorded as what they think, encouraging the description of objects exactly as they are intuited (Maggs-

Rapport, 2001; Giorgi, 1997). The objects can be things such as tables, houses, people, and/or psychological phenomena such as remembering, imagining, and planning (Husserl, 1970). So phenomenological reduction is a dynamic means for examining participants' natural attitudes toward their experiences (Bevan, 2007).

Husserl identifies two types of phenomenological reduction: psychological phenomenological reduction and transcendental phenomenological reduction. Transcendental reduction is hierarchically above psychological reduction and used by philosophers interested in pure essence (Husserl, 1970). It requires researchers to detach from all of their experiences and understandings of the real world, no matter how they are relevant to the phenomenon of interest, so that this phenomenon can be examined as purely as possible, without elements of the natural world influencing the examination process (Bevan, 2007). Psychological phenomenological reduction is a bracketing of the world to make the experiences and natural attitudes being studied more accessible to researchers (Giorgi, 1997). That is, the researcher should bracket his or her existing values and judgments concerning the phenomenon of interest, but not undermine or doubt participants' descriptions (Levinas, 1998).

There are critiques of Husserl's pure essence and the transcendental phenomenology reduction. Many subsequent phenomenologists, including Heidegger, have pointed out that this idealist notion is not practical in research (Ihde, 1986). When it is detached entirely from the world, the phenomenon of interest also loses its own meaning completely, because its meaning comes from the world.

As it aimed to discover what elders and their children experienced during the decision-making process around institutionalization, this study emphasized psychological phenomenological reduction and tried to reveal the essence of participants' experience.

Epoché. Epoché is the first step for conducting a phenomenology study (Zaner, 1975). Epoché refers to a critical stand of researchers that requires them to take nothing for granted. Only through the epoché does the researcher perform the reduction (Zaner, 1975), which focuses on a phenomenon as it appears: a return to the phenomenon itself (Creswell, 2007). It takes a step back to describe an existing experience as a presence (Giorgi, 1997).

Despite the differences in approach between psychological reduction and transcendental reduction, the fundamental processes of epoché remain the same (Giorgi, 1997). Husserl (1970) stresses that researchers should undertake the phenomenological reduction by “putting out of play”—seeking validation of participants’ beliefs, knowledge, and attitude toward their experiences. Thus, epoché asks the researchers to take a critical stance during the investigation in relation to their own beliefs, knowledge, and attitudes toward the phenomenon of interest.

Bracketing. Bracketing is the next step for phenomenological reduction. Bracketing is simply the suspension of take-for-granted knowledge of the phenomenon of interest, so it may present itself with the essence (Creswell, 2007). The researcher needs to avoid any presumable suppositions, but believe in the existence of the phenomenon of interest (Bevan, 2007). Besides trying to minimize the implications of theory-laden observations, this is another reason for the author to keep a blank column labeled “after the interview” in Table 2 in Chapter III.

It is necessary to point out that bracketing is also a dynamic process. Researchers need to constantly appraise their own stand, compared with participants’ descriptions throughout the study, and treat every aspect of the phenomenon of interest as equal as well, in order to avoid any of their own assumptions (Bevan, 2007).

The search for the essence. By investigating intentionality, exploring typifications, and performing phenomenological reduction, the phenomenological approach aims to search for the essence of participants' experiences of the phenomenon of interest. It seeks a fundamental, unchanging structure of their consciousness pertaining to the experience.

For this study, a phenomenological approach was ideal to explore elders' and their children's retrospective views of their experiences of deciding to institutionalize, as the participants had already apprehended and made meaning out of these experiences: 1) What the decision to institutionalize meant to them; 2) how they communicated with each other to reach the final agreement; and 3) how the intergenerational communication served to manage the uncertainty of institutionalization.

Furthermore, the author recorded elders' and their children's intentionality based on their interpretations of the typifications of nursing home care, family caregiving, and intergenerational relationships, whose meanings may be evolving and no longer significant in the decision-making process. The author also explored under what circumstances these traditional typifications about caregiving became meaningless and began to transform or what incidents triggered these transformations, and what psychosocial contexts fueled these transformations. These typifications and their transformation helped to clarify the underlying meanings of caregiving arrangements embedded in intergenerational communication.

Researcher stance and bracketing. Given the interacting nature of qualitative studies, in this study, the author became the instrument to write research questions that explored the meaning of the experience of making the decision to institutionalize and to collect data from residents and their children who have had such experiences. However, the author was cautious about her own self-reflection on the phenomenon of interest (Creswell, 2007). The author

bracketed her knowledge, understanding, and experience of interviewing nursing home residents before she went into the field and conducted interviews, in order to minimize the influence of her previous study on elderly residents' perspectives on institutionalization and filial piety (Chen, 2011). During the interviews, she avoided assumptions, judgments, and values as much as possible. She also appraised her stand throughout the data collection procedures.

Qualitative research is interpretative in nature, with the researcher typically involved in a sustained and intensive experience with participants (Creswell, 2007). This introduces a range of strategic, ethical, and personal issues into the qualitative research process (Locke, Spirduso, & Silverman, 2000). First, with these concerns in mind, and as a member of the Chinese culture, the author showed her respect to nursing home residents by using honorific titles throughout the interview, bowing to them as a formal greeting in the beginning of the interview, and bowing to them again at the end of the interview. The author was also polite when interviewing their child caregivers by using socially proper manner of greeting.

Second, the author was sensitive to the modes of intergenerational communication in Chinese families. That is, family members tend not to discuss emotions and personal preferences that may conflict with others in the family. As an insider of Chinese culture, the author was able to capture some underlying meanings of participants' expressions, with detailed probing. These underlying meanings are important in terms of revealing the typifications of contextual and psychosocial factors involved in the decision to institutionalize. However, some of the probing remained purposefully indirect, in consideration of Chinese conversational culture.

Third, the author was cautious about the boundaries of interview questions. The author was aware that the interview questions include some highly private issues about participants' lives and caregiving and living arrangements. There were certain issues, such as

intergenerational conflicts and face-saving, which were essential to the study and yet required particular sensitivity to boundaries. The author was alert to the physical expressions of participants in the interview to avoid crossing these boundaries.

Study Settings

The author conducted a purposive sample at a government-supported, municipal-level not-for-profit nursing home in Shanghai. The history of this nursing home providing institutional healthcare for elders traces back to 1736; it is the oldest nursing home in Shanghai. The nursing home was located in the center of Shanghai. The number of total beds in the nursing home was 320. The average age of residents was 82.3 years old. The nursing home was divided into three parts in the two five-floor buildings: independent living, assisted living, and a constant-care area. Independent living area was for relatively healthy residents with a minimum level of care. Assisted living area was for those who had some physical disabilities and needed a moderate level of care. The constant-care area was mainly for residents suffering from severe cognitive impairment. Nine residents interviewed were living in the independent living area, and three residents interviewed were living in assisted living area. This nursing home was similar to a skilled nursing facility in the United States that has residential physicians to administrate medications.

This nursing home was directly operated at the municipal level and subsidized by the Shanghai Civil Affairs Bureau every year. It cost 1,000 *yuan* per month (about \$160) for elders living in the independent living area and 1,200 – 1,500 *yuan* per month (about \$192 – \$240) for elders living in the assisted living area. Compared with private nursing homes in Shanghai, the

fees charged by this nursing home were barely half of the average fees of a private one, which was 2,400 *yuan* per month in 2011 (about \$384; Shanghai Statistic Bureau, 2012).

The average individual pension was about 1,800 *yuan* per month for participating elders (about \$288), which is comparable to a retirement plan in the United States. This amount was about 25% less than the average individual pension, 2,278 *yuan* per month (about \$365), of the aging population (65+) in Shanghai in 2011 (Shanghai Statistic Bureau, 2012). But their pension was able to cover the fees in the current nursing home.

Sampling

Residents' inclusion criteria. The criteria for residents' participation included: (1) aged 65 and over; (2) widowed or widower; (3) minimal cognitive impairment symptoms as assessed by an evaluation to give consent; (4) parents of Chinese baby boomers, who were born in the 1950s and 1960s; (5) had experiences of living with children before moving into the nursing home; (6) were previously taken care of primarily by daughters or daughters-in-law at home; and (7) Shanghai locals with middle-class pension.

Residents' exclusion criteria. Nursing home residents with only spousal caregivers were not eligible.

Children's inclusion criteria. Nursing home residents helped to identify their children who were their primary caregivers before institutionalization to participate in the study.

Recruitment. The author first purposefully identified one government-sponsored, municipal-level nursing home as the study site in Shanghai. Purposeful sampling is a method that is typical in qualitative research (Patton, 2002). The logic of purposeful sampling lies in selecting participants with insights and understandings of the phenomenon of interest.

The rationale for choosing government-sponsored nursing homes was their relatively lower fees for residents and their children. This characteristic attracts more elders in need and their children (Chu & Chi, 2008). For the purpose of this study, the government-sponsored nursing home helped to draw a more homogeneous sample. Then a purposive “snowball” sampling strategy was used to recruit participants according to the inclusion criteria, with the help of social workers’ recommendations.

Noticeably, residents in the private nursing homes may be better off than elders from average families who live in a government-sponsored nursing home. The decision to enter a private nursing home may have more to do with elders’ or their families’ ability to afford this type of facility than with other psychosocial contexts. Recruiting from a private nursing home would bring in a different population of elders and families and potentially a different decision-making process, shifting away from the focus of this study. The criterion of government-sponsored nursing homes can contribute to controlling the financial characteristics of nursing home residents and their children. This supports the aim of this study to gain a deeper understanding of psychosocial contexts in the decision to institutionalize among nursing home residents. However, this study was not limited to financial factors, as was a large body of studies in the United States has mainly focused on financial factors (Stone, 2000; Kane et al., 1998).

Sample size. The author interviewed 12 dyads of nursing home residents and their children. However, the unit of observation was the interview, so the final observational sample size was 24. Each dyad consisted of one nursing home resident matched with one of his/her children.

Although qualitative inquiry does not require specific rules for sample size (Patton, 1990), the final sample size of 24 is justified. The decision-making processes that emerged from the

data became redundant, that is, the basic patterns reappeared in each subsequent case analysis. Thus, the 24 interviews were considered sufficient for the purposes of this study.

Study Procedures

Informed consent. The author conducted three site visits and obtained agency approval before the actual study began in July 2012.

First, the author asked the residential physician and chief social worker in the nursing home to identify 20 potentially eligible residents, with no signs of cognitive impairment. Then, the author held an information-briefing session for these potentially eligible residents at their convenience. During the session, the author introduced the background, main research questions, and study design to the potentially eligible residents. The author answered their questions and addressed their concerns. Nursing home residents learned about their rights in the study. The author emphasized that participation was voluntary, and that refusal to participate would have no impact on their situation and services in the nursing home.

When some of the residents agreed to participate in the study, the author provided them a written consent form (approved by the Office of Human Research Protection Program at UCLA) in Chinese and reviewed it with them. After residents gave their oral consent, the author arranged the interview at their preferred time and location.

When residents agreed to invite their children to participate, the author also asked the nursing home to contact residents' children. Talking by phone with their children at first, the author introduced the background, main research questions, and study design to them. After the children agreed to participate, the author asked them to come to the nursing home at their convenience and give their oral consent. Children's consent especially emphasized that their

participation was voluntary and that their refusal to participate would have no impact on their parents' services in the nursing home.

Data Collection. The data collection consisted of two separate phases of face-to-face, semi-structured in-depth interviews. The first phase was to interview residents. The second phase was to interview matched children of these residents. Topics included, but were not limited to, family caregiving contexts prior to institutionalization, health conditions prior to institutionalization, communications and negotiations between generations, uncertainties in the process, factors influencing the decision-making, and the final decision.

The rationale for separating interviews with elders and their children was to avoid potential data contamination; that is, elders and their children might have masked their true answers about the intergenerational communication on the decision to institutionalize if they had been interviewed together. All interviews were conducted in a private conference room in the nursing home for half an hour to 2 hours, lasting for around 1 hour on average.

Interviews were carried out in Mandarin and Shanghainese. These interviews were conducted in person and audio-recorded in their entirety, with the permission of all the participants. Questions were open-ended to introduce a topic, and encouraged participants to talk about their experiences of deciding to institutionalize. The author used prompts and probing strategies to encourage participants to explore more in-depth ideas and topics, such as, "Please tell me more about that" or "What examples come to mind about...?" The author also recorded the observations of each participant's appearance, facial expression, body language, environment, and degree of comfort during the interview, paying special attention to his or her feelings of comfort/discomfort. These observations provided a context for transcribing the interviews and an

opportunity to establish interviewer and environmental factors that may have colored the interview.

Data analysis. The author transcribed and translated interviews into English immediately after each interview. The translation aimed to convey the entirety and emotions involved, so they were not necessarily verbatim. After each interview, a preliminary analysis extracted key points for the author's reference to be used in the following interviews.

The author contacted participants a second time if there were any questions or areas in need of clarification relative to their interviews, approximately one week after the interview or after the interview was transcribed. This time period allowed the author to check themes and categories to assure relevance to participants' experiences and accuracy in representing those experiences (Creswell, 2007; Patton, 2002).

All interview data were analyzed together. Transcripts and field notes were entered into the *Atlas.ti 7.0*, a qualitative toolbox program, which enables the efficient storing, retrieving, and sharing of data. Data analyses were concurrent with data collection in order to identify when saturation had been reached. According to Creswell (2007), phenomenological data analysis consists of a series of steps. The original transcriptions were divided into statements. Then these statements were transformed into clusters of meanings describing concepts relevant to the phenomenon of interest. Finally, these transformations were linked together to create a general description of the essence of the phenomenon. The general description can be a textual description of what was experienced, as well as the structural description of how the experience was experienced (Creswell, 2007).

Thus, the author analyzed the data by identifying significant statements, themes, patterns, and qualitative descriptions in the transcribed interviews. Initially, the complete interview

transcriptions were read thoroughly to do open coding. Codes were the same words used by participants, to retain the authenticity, and were gathered in the master matrices in the codebook for references. After open-coding, segments of coded data were brought together into codebook matrices, which allowed for identification of themes and comparison across the dyads of participants (i.e., nursing home residents and their children). Description and interpretation were used to identify similar and different views within and/or among dyads of participants. In particular, the author identified significant statements that pertained directly to participants' experiences of deciding to institutionalize. Meanings were formulated from the significant statements. Then these codes and significant statements were clustered into themes allowing for the emergence of themes common to all the participants' transcripts. The author read through these themes and further grouped them into categories. Then the author grouped these categories into families to distill the essence of participants' experiences of deciding to institutionalize.

Furthermore, the author employed a dyadic perspective to cross-compare the transcripts from the individual retrospective interviews within each dyads of both generations, in order to highlight the intergenerational communication. She kept comparing the inter-dyad and intra-dyad characteristics and experiences throughout the 12 families. In addition, an expert in qualitative analysis (Dr. Lené Levy-Storms) periodically reviewed and oversaw the analysis during all stages of the study.

After thoroughly reading through the different significant statements, themes, categories, and families, the author reread the original transcripts to ensure that no main themes or families remain unidentified. The author continued writing memos during the analysis process to supplement the initial open coding, categorizing, and classifying (Creswell, 2007; Patton, 2002).

The author adhered to the phenomenological methodology throughout data collection and data analysis. She tried to bracket as much as possible of her past experiences and knowledge of the phenomenon of interest in data collection and data analysis. The author also kept field notes, reflexive journals, and memos as audit trails.

The next chapter will present the findings of this phenomenology study.

CHAPTER V

Results

This chapter reports the results of the phenomenology study. It will first introduce participants' profiles and their family caregiving contexts. Then it will illustrate the experiences of deciding to institutionalize among the 12 dyads.

Participants' Profiles

A purposive sample consisted of 12 elders, three males and nine females. This gender ratio was obtained intentionally to roughly reflect that in the nursing home of 1 to 4, male to female. All elders were over 80 years old. On average, they had spent a little over 3 years in the current nursing home. They were all widowed, but had four children on average. All elders had lived with their children prior to institutionalization. Almost half of the elders perceived their health conditions as stable. Participating elders' detailed demographic characteristics appear in Table 3.

Participating elders identified their primary caregivers as the adult child with whom they had lived with before institutionalization. Table 4 presents participating children's age, gender, and relationship with elders. Eight child caregivers were sons, and four were daughters. Eight children were the youngest children. Three sons were the eldest. One child was the second daughter. The average age of children was 55.25 years old ($SD = 4.35$), ranging from 49 to 61 years old.

Table 3

Demographic and Health Characteristics of Participating Elders (N = 12)

| | Women (N = 9) | Men (N = 3) |
|---|---------------------------------------|---------------------------------------|
| Age (years) | 81–92 (Mean = 86.33, SD = 3.50) | 81–87 (Mean = 83.67, SD = 3.05) |
| Length of residence (years) | 1–9 (Mean = 4.28, SD = 2.56) | 1.5–2 (Mean = 1.83, SD = 0.29) |
| Number of children | 3–5 | 3–5 |
| Marital status | Widowed | Widowed |
| Individual pension income | | |
| 500 – 999 <i>yuan</i> * | 1 (11.1%) | 0 |
| 1,000 – 1,499 <i>yuan</i> | 2 (22.2%) | 1 (33.3%) |
| 1,500 – 2,000 <i>yuan</i> | 6 (66.7%) | 2 (66.7%) |
| Living arrangement before institutionalization | | |
| Living with sons | 7 (77.8%) | 1 (33.3%) |
| Living with daughters | 2 (22.2%) | 2 (66.7%) |
| Self-perceived health status | | |
| Relatively healthy | 4 (44.4%) | 1 (33.3%) |
| Not healthy | 5 (55.6%) | 2 (66.7%) |
| Chronic diseases for elders who considered themselves unhealthy [†] | | |
| Asthma | 0 | 1 (50%) |
| Cataract | 3 (60%) | 0 |
| Coronary heart disease | 1 (20%) | 0 |
| Diabetes | 2 (40%) | 0 |
| Minor stroke | 0 | 1 (50%) |

* At the current exchange rate, 100 *yuan* equals roughly \$16.

[†] These elders had multiple chronic diseases.

Table 4

Participating Children's Relationships with Their Parents (N =12)

| Children | Age | Relationship with parents |
|------------------------|------------|------------------------------------|
| Mr. Chen ¹² | 58 | Eldest son |
| Mr. Lin | 61 | Eldest son |
| Mr. Yang | 59 | Eldest son (2 nd child) |
| Mr. Fan | 52 | Youngest son |
| Mr. Huang | 53 | Youngest son |
| Mr. Shen | 55 | Youngest son |
| Mr. Zhang | 52 | Youngest son |
| Mr. Zhou | 49 | Youngest son |
| Ms. Ye | 60 | Eldest daughter |
| Ms. Nie | 61 | 2 nd daughter |
| Ms. Cao | 53 | Youngest daughter |
| Ms. Wang | 50 | Youngest daughter |

¹² All participants' family names are fictitious.

Etiology of Family Caregiving

This section presents the participants' family caregiving contexts, including their experiences of co-residence, the implications of children's gender for family caregiving, and intergenerational relationships before institutionalization.

The unexpected reality of family caregiving: "It's like I was an intruder." All participating elders lived with one of their children prior to institutionalization. Most elders moved to their children's homes after their spouse passed away, at the request of their children. Children chose co-residence primarily to monitor their parents' health status and provide necessary instrumental support. For example, Mr. Wang-E¹³ lived alone for several months after his wife passed away. But Ms. Wang-C insisted on him living with her due to his unstable health condition.

However, co-residence did not necessarily benefit elders. First, different living habits between generations negatively affected co-residence. For example, Mrs. Shen-E mentioned that her different dietary preferences from her daughter-in-law had caused friction. Mrs. Zhang-E reported that the different living schedule between generations disturbed her life greatly during co-residence with her youngest son. Second, the condition of children's apartment did not suit elders' needs. For example, without elevators, it was difficult for Mrs. Shen-E to go up and down the stairs in a six-floor building. Mr. Zhou-C found his apartment was not optimal for his father's health condition:

Due to his asthma, my father's very alert at night. He's very sensitive to the noises. But my apartment is quite old, which is not that soundproof. It was not possible for him to sleep well. He complained a lot.

Mr. Huang-C considered the limited space in his apartment an impediment to him providing better family caregiving:

¹³ E and C indicate elders or children.

We do not have the space for a paid caregiver to live with us, but we actually needed one to take care of my mother at night. She had some heart problems, which broke out at night from time to time, but my apartment is too small for five people.

In particular, housing was linked to the quality of care for elders during co-residence with their children. Several elders experienced disrupted family caregiving because of housing issues.

For example, Mrs. Huang-E moved between her two sons' homes:

I had lived with my eldest son since my husband passed away, in the traditional way [of family caregiving]. However, he was diagnosed with cancer several years ago, so it was impossible for me to continue to live with him. His son, my eldest grandson, took my old apartment to get married. I had basically nowhere to go. My eldest son asked his younger brother to take care of me. So I had to live with my youngest son's.

In order to ensure co-residing family caregiving, several elders exchanged their property for their children's caregiving. For example, Mrs. Nie-E said:

Actually, the apartments of my two sons are from my husband and me. We moved out of our old house, where new high-rises were going to be built. The government compensated us with two apartments. My husband and I decided to give our sons the two apartments and they agreed that, in turn, they would take care of us until we passed away.

However, this property exchange did not guarantee that elders would receive sufficient or proper caregiving from their children, but rather disrupted elders' caregiving arrangements. For

example, Mr. Zhou-E was asked to move out of his daughter's apartment, as he gave his old apartment to his youngest son:

When my wife fell ill, my daughter suggested that we move to her place, which was close to the hospital. Her place is quite spacious, so we thought that we would live with my daughter's family for the rest of our lives. So my wife and I decided to give our youngest son our apartment, because we were always fond of him. After my wife died, my daughter felt it was unfair that we gave the apartment to her younger brother instead of her. In fact, she had done all the heavy lifting to take care of their mother, not her brother. She did not want to take care of me anymore. She asked me to leave her home...

As both generations implicitly agreed, the child who received the property was supposed to undertake most of the caregiving responsibilities. So Mr. Zhou's daughter did not want to continue to take care of him, because she was not compensated. Ms. Wang-C took her father's

apartment and she had to perform all the caregiving duties, whereas her brothers did not undertake any caregiving duties, contrasting to the male dominated caregiving traditions, simply because they did not have their father's property. When a child or a grandchild had the property but did not perform caregiving duties, it was unacceptable to other children. Mr. Huang-C, for example, complained about his nephew:

After my nephew got my mother's apartment, he did not take care of his grandma at all. I understood that my eldest brother was too sick to take care of our mother, but what about his son? While his son kept the apartment, my mother had nowhere to go but live with me. It was like [my eldest brother's family] dumped my mother on me. I am her son. Who else can she depend on? I had to step up...

Exchanging property for caregiving caused conflicts among siblings in terms of unbalanced demanding caregiving responsibilities and unfair compensation from their parents. This exchange also added additional emotional disturbance to elders during co-residence. For example, Mrs. Nie-E and Mrs. Yang-E expressed their loss of a sense of belonging after giving their old apartments to their grandsons. Mrs. Zhang-E felt unwanted after losing her apartment and being bounced among her children. Mrs. Fan-E said, "I never felt at home after giving my son the apartment, even when I lived with him in the same apartment." These elders felt frustrated, powerless, and disappointed throughout the co-residence period.

Co-residence became exclusively a vehicle for instrumental support to children, but it was increasingly unreliable for their parents. In order to maintain their caregiving expectations, some elders exchanged housing to ensure their children's family caregiving. But their attempts were not always successful. Some of their children failed to maintain the exchange, which disrupted elders' caregiving arrangements. Such disrupted family caregiving not only caused misunderstanding between generations as well as among siblings, but also exposed elders to some emotional disturbance.

The caregiving gender paradox. Both generations stated that sons possessed greater power in family decision-making compared with daughters. For example, Mrs. Zhang-E and Mrs. Shen-E pointed out that only their sons could decide important issues regarding the whole family, for example, parents' caregiving arrangements. A couple of elders expressed how much they adored their sons and bestowed property on them. For example, Mr. Zhou-E said that he always fancied his youngest son, so he decided to give his apartment to him instead of his second daughter, who in fact had provided more caregiving to his late wife. In particular, eldest sons became the heads of the family after their fathers passed away in most participating families. For example, Mrs. Nie-E described how her eldest son decided her living arrangement:

[Eldest son said,] "Our younger sister has the largest apartment among the three of us; you should live with her. My son is going to get married really soon. He needs more space here." He called his sister and told her about his plan. My daughter didn't say anything, because her eldest brother made all the decisions for the whole family.

However, sons' greater power in the family sometimes meant more caregiving responsibilities for them than for their sisters. For example, Mr. Chen-C had to retire early to better attend to his paralyzed father. Mr. Huang-C, rather than his sisters, had to take care of his mother, when his eldest brother was diagnosed with cancer and could no longer provide caregiving. Mr. Yang-C expressed his strong feelings about being the eldest son:

After my father passed away, I am the head of the family who make decisions for the whole family, because I am the eldest son. Most importantly, I have to perform the duties of an eldest son—taking care of my frail parents until they pass away.

However, most elders agreed that their daughters and daughters-in-law still undertook the actual caregiving duties that complied with filial piety, regardless of the relationship between them or the quality of care. Among the 12 participating elders, daughters of Mrs. Lin, Mrs. Nie, and Mrs. Cao were their mothers' primary caregivers, and Mrs. Zhang, Mrs. Chen, Mrs. Huang, and Mrs. Yang were taken care of by their daughters-in-law. In terms of the quality of care,

elders considered daughters and daughters-in-law more reliable than sons. For example, despite the rather difficult relationship with her, Mr. Zhou-E still appreciated his daughter for her previously meticulous care for his late wife. Mrs. Ye appreciated her daughter's care, even though they had had frequent quarrels during co-residence.

Thus, sons had greater power in caregiving decision-making for their parents and undertook comparatively more caregiving responsibilities than their sisters. However, daughters and/or daughters-in-law performed the actual caregiving duties. This gender paradox may have caused miscommunication and misunderstandings about caregiving and its further arrangements between generations.

Familial discordance regarding caregiving tradition: “It’s not the same now.” Filial piety strongly emphasizes children as “insurance¹⁴” for people’s later life. Several families enjoyed good intergenerational relationships before institutionalization. For example, the Shen family maintained a close and strong emotional connection between generations. However, most elders admitted that they had strained relationships with children or children-in-law, which culminated during co-residence. In particular, the strained relationships with their children-in-law significantly disturbed elders’ caregiving. For example, Mrs. Huang-E disliked her daughter-in-law’s attitudes toward co-residence:

Daughters are families. Daughters-in-law are not families after all. I did not get along well with my youngest daughter-in-law. She is not a good wife. She cannot cook... I was sure that I could not be taken good care of when I started living with them. She thought she offered me a place in her home, which was more than enough.

Mrs. Nie-E described the conflicts with her son-in-law:

My son-in-law just didn’t want to live with me. He accused me of spending a lot of his money. It was so ridiculous. He was so unreasonable. I didn’t want to live with him anymore.

¹⁴ Chinese elders tend to consider their children as a type of healthcare insurance when they become old and frail (Chen, 1996; Rubinstein, 1987; See Chapter II).

Despite strained intergenerational relationships, most elders maintained a strong belief in filial piety as their “insurance” for caregiving. For example, Mrs. Lin-E represented most elders’ views:

You know, we Chinese elders, especially like me, an almost disabled old lady, want to rely on our children, not paid caregivers, not nursing homes; it’s our tradition, isn’t it? If everything was fine, like if my eyesight was fine, if my leg wasn’t injured, I would like to stay at home and my children could take care of me, which would not be too much for them to do.

Contrary to their parents’ views, children’s definition of filial piety only covered the very basic element, that is, instrumental support. For example, Mr. Huang-C stated that no relationship existed between him and his mother:

There is no relationship. Only responsibility left. It is only children’s responsibility. Of course, I care about my mother... It’s my responsibility to provide enough instrumental support to her, but nothing more.

This discrepancy between children’s declining beliefs in filial piety and elders’ high-standard caregiving expectations led to caregiving discordance. For example, Ms. Ye-C described the misunderstanding with her mother:

We had troubles in communication for a long time. She did not think I perform the full filial piety to her. She always doesn’t listen to me. She wanted to do everything her way and thought I would harm her... She thinks I am a bad daughter who doesn’t care about her. We used to have so many fights, as she did not think I absolutely devoted to taking care of her.

So the once congruent understandings of filial piety between generations departed from elders’ integrated caregiving expectations—including instrumental and emotional support—and made way for children’s oversimplified notions of instrumental support only.

Therefore, co-residence enabled children to provide essential instrumental support for their parents prior to institutionalization. However, unsuccessful exchanges of property for caregiving, unbalanced power between sons and daughters, and different caregiving expectations

between generations caused discordant family caregiving that may have catalyzed the decision to institutionalize.

Two Players in One Game

The 12 families decided to institutionalize under different caregiving circumstances. Table 5 outlines major processes of participant's decision-making around institutionalization, including who initiated the process, their primary reasons for institutionalization, whether the elder was involved in the decision-making, and who made the final decision.

Table 5¹⁵*Major Processes of the Decision to Institutionalize in the 12 Dyads*

| Who initiated the decision? | Primary reasons for institutionalization | Were elders involved? | Who made the final decision? |
|------------------------------|---|-----------------------|---------------------------------------|
| Mrs. Fan (mother) | Feeling lonely at home | Yes | Mr. Fan and his eldest brother (sons) |
| Mrs. Huang (mother) | Strained relationship with her daughter-in-law | Yes | Mrs. Huang (mother) |
| Mrs. Nie (mother) | Disrupted family caregiving and strained relationship with her son-in-law | Yes | Mrs. Nie (mother) |
| Mrs. Shen (mother) | Preferred collective lifestyle | Yes | Mrs. Shen (mother) |
| Mr. Chen (eldest son) | Father was paralyzed; father and mother were institutionalized together | Yes | Mr. Chen (eldest son) |
| Mr. Lin (eldest son) | Mother fell and had surgery | No | Mr. Lin (eldest son) |
| Mr. Yang (eldest son) | Not safe to leave mother alone at home | No | Mr. Yang (eldest son) |
| Mr. Zhang (youngest son) | Mother's worsening diabetes | No | Mr. Zhang (youngest son) |
| Mr. Zhou (youngest son) | Father's severe asthma | No | Mr. Zhou (youngest son) |
| Ms. Ye (eldest daughter) | Mother fell and her ankle was fractured | No | Ms. Ye (eldest daughter) |
| Ms. Wang (youngest daughter) | She herself had medical problems due to a car accident | Yes | Ms. Wang (youngest daughter) |
| Ms. Cao (youngest daughter) | Not safe to leave father alone at home | No | Ms. Cao (youngest daughter) |

¹⁵ Appendix D presents detailed family synopsis.

Figure 3 further categorizes the 12 families in terms of who initiated the decision and their primary reasons for institutionalization. Four elders voluntarily proposed to institutionalize due to: 1) strained intergenerational relationships (Mrs. Fan and Mrs. Nie) and 2) loneliness and potentially growing caregiving burdens (Mrs. Huang and Mrs. Shen). Children proposed to institutionalize in the remaining eight families due to: 1) other family members' health conditions (the Chen and Wang families); 2) children's caregiving precautions (the Cao and Yang families); and 3) elders' deteriorating health conditions (the Lin, Ye, Zhang, and Zhou families).

The 12 families' experiences of deciding to institutionalize will be presented in the order stated above.

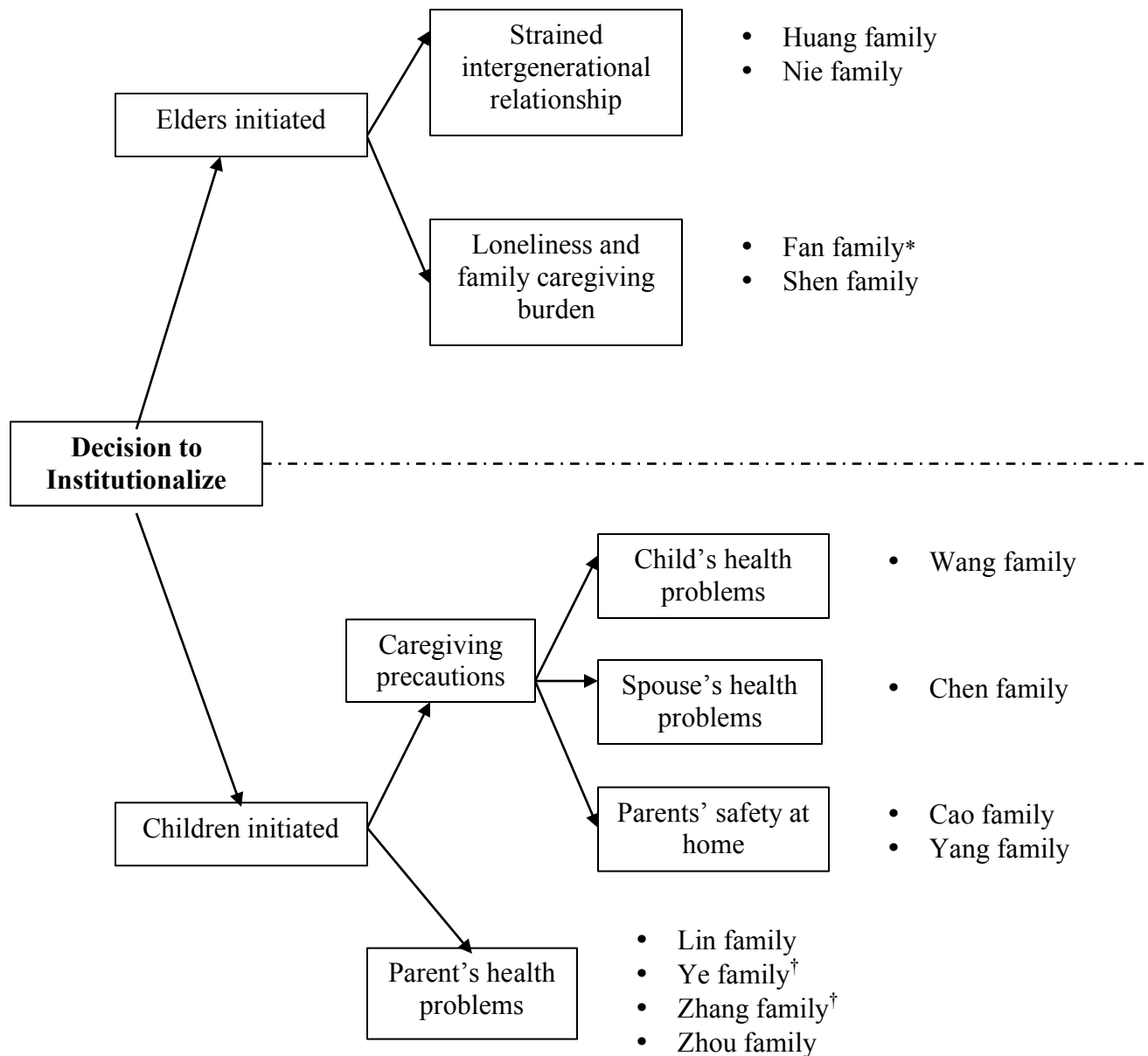


Figure 3. Families categorized by which generation initiated the decision to institutionalize and their primary reasons.

*Mrs. Fan moved to the current government-sponsored nursing home twice in 3 years.

†Mrs. Ye and Mrs. Zhang had respectively lived in private nursing homes for several months before moved to the current government-sponsored nursing home.

Seizing remaining decision-making autonomy. Four elders (Mrs. Fan, Mrs. Huang, Mrs. Nie, and Mrs. Shen), with their relatively stable health conditions, voluntarily proposed to institutionalize. Mrs. Fan proposed twice because she was too lonely at home:

The first time that I wanted to move to a nursing home was about 3 years ago. I lived with my son's family and his father-in-law as well. But my in-law [my son's father-in-law]¹⁶ was very ill at that time. My son and daughter-in-law were not as attentive to me as to him. I felt lonely and bored at home. So I told my son that I wanted to move into a nursing home. He agreed. The second time was after my in-law passed away. I officially had no one to talk to. So I asked my son to take me here again.

Mrs. Shen did not want to burden her son's family and wanted to have a more active lifestyle:

My husband had already burned them out. I did not want to trouble them anymore. They have to take care of my grandson as well. I have always been fond of collective life, so I decided to come here.

Mrs. Nie was disappointed about family caregiving:

I was like a ball bounced among my children. No one wanted me. So I had the idea of institutionalization. In particular, I didn't want to live with my son-in-law any more. I told my daughter that I wanted to live in a nursing home to live on my own.

Mrs. Huang decided to institutionalize to maintain her independence:

I wanted to institutionalize. I had to seek a way out for myself, as none of my children was willing to take care of me.

So Mrs. Fan and Mrs. Shen sought more social interaction, because they were lonely at home.

Mrs. Huang and Mrs. Nie, however, desired more reliable healthcare services, because unstable caregiving arrangements and strained relationships with children-in-law made them feel unwanted at home. Using their remaining decision-making autonomy, these four elders decided to institutionalize before their children suggested it.

The children of these four elders reacted differently. Mr. Shen-C did not expect his mother to suggest institutionalization, so he was strongly against it at first:

¹⁶ Mr. Fan-C lived with both his mother and his father-in-law.

I was so surprised. I did not expect that at all, since my father had just passed away. I insisted that she should stay with us. But in the end, I agreed with her because I had to respect her decision.

However, the other three families took a smoother path to reach consensus. Mrs. Huang-E described her children's initial mixed reactions:

I persuaded my youngest son to help me move. My eldest son was furious about my decision. He said, "You are not childless, mother. We can take care of you. Otherwise, people would think we are abandoning you." My daughters did not say much, but they thought institutionalization was worth trying. They knew that I was unhappy living with their younger brother. But after all, I am their mother and I made the decision.

Some children united behind their parent. Ms. Nie and her siblings discussed this issue and agreed with their mother's decision. Mr. Fan described family meetings with his siblings to discuss their mother's proposal:

I gathered my siblings together to discuss this decision several times. We agreed with our mother to take advantage of the professional healthcare in the nursing home. We had the second meeting about which nursing home to send our mother to. We had consensus about all kinds of categories, such as food, services, staff, and administration. In fact, my eldest brother finalized the decision to choose this nursing home.

These four children showed mixed feelings about their mothers' decision to institutionalize. They understood that their mothers were considerate and willing to reduce their increasing caregiving pressure. However, they agreed to institutionalize their mothers somehow reluctantly, because they were able to provide adequate instrumental support, and they understood that institutionalization was not a socially desirable long-term care option for elders.

Despite various family caregiving situations, these four elders were exceptionally motivated to change their caregiving arrangements and maintain their autonomy. Taking the initiative, they decided to institutionalize, which demonstrated their relative empowerment and independence.

Preempting caregiving depletion. Children from four families (the Cao, Chen, Wang, and Yang families) took precautions to institutionalize their parents. Children in the Chen and Wang families decided to institutionalize due to family members' health problems that exceeded the overall caregiving capacities. For example, Ms. Wang-C had a car accident when her father was recovering from a minor stroke, which interrupted family caregiving:

I know that institutionalizing my father is not quite traditional. But it was for my father's best interest. Of course, I had to consider my health as well. If I could not continue to take care of him, my father would have no one to take care of him... To be frank, if I had not had the accident, probably I would have not been able to take care of my father as well. I am 50 years old already. I am not young anymore.

Mr. Wang-E understood that institutionalization could relieve family caregiving:

I pitied my daughter and son-in-law. She had the awful car accident. I was too weak to do anything at that time. I didn't want to burden my daughter. So I agreed to move into this nursing home.

When Mrs. Chen-E fell ill herself, family caregiving was collapsing:

My paralyzed husband used to rely most on me. When I was hospitalized due to pneumonia, it was impossible for my eldest son and his wife to take care of him alone. I knew we were not able to take care of my husband any more. I agreed with my son's suggestion to institutionalize him.

Mr. Chen-C recalled that family caregiving could not continue when his mother was hospitalized, because he was not able to take care of both sick parents. However, Mr. Chen's father protested against the decision to institutionalize:

My father was really traditional. He thought children's taking care of parents was an unalterable truth. He didn't accept being taken care of by other people in a strange place, even if they had professional healthcare skills. He was strongly against our decision. He stopped eating for a day to protest. Our mother persuaded him by moving here with him.

Ms. Wang-C and Mr. Chen-C, realized that they had to find an alternative to family caregiving before all their resources were depleted. As they witnessed the impending collapse of

family caregiving, Mrs. Chen-E and Mr. Wang-E not only understood their children's decisions, but also participated in the decision-making process.

Children in the Cao and Yang families took precautions by proposing institutionalization to avoid potentially increasing caregiving burdens, regardless of their parents' stable health conditions. Mr. Yang-C decided with his siblings to ensure their mother's safety:

I was worried that my mother was too old to take care of herself. She may forget to turn off the gas or fall when she's out shopping. Staff in the nursing home can monitor her.

Ms. Cao-C and her sisters considered institutionalization for the same reason—their father's safety:

If anything happens to him, it is not safe for him to stay home alone during the day. Moreover, those people [who our brother owed money to] had already found my home. I was afraid that they might harm my father. After all, he is getting older and older. I just don't want to take any chances.

Their parents, Mr. Cao-E and Mrs. Yang-E, were strongly against the decision to institutionalize at first, because their health conditions were comparatively better for their age. They considered they could live independently. Mrs. Yang-E blamed her daughter-in-law for avoiding caregiving responsibilities:

I knew it was her idea! We didn't get along from day one. She just wanted to get rid of me. She did not want me to be happy, so I would not let her be happy as well. So I rejected their suggestion immediately.

Mr. Yang-C understood that his mother might have felt abandoned, but he insisted, "If anything happens to my mother when she is alone at home, I cannot handle the situation." Mrs. Yang-E finally agreed to institutionalize because of her strong feeling of obligations to her son:

My son told me that he had done some research and pulled some connections to find me a bed in this nursing home. I knew I could not insist on staying with him any more. I had to accept his decision.

Mr. Cao-E changed his mind based on other advantages of nursing home care:

I was against the idea at first. But later, I remembered that when my wife was in the hospital, other patients told us that children were not as reliable as nursing homes. So I decided to try. Also, a plus of institutionalization is that I can hang out with some of my old friends, as the nursing home is not far from where I used to live. My daughter did not let me go out when I lived with her.

Mr. Yang-C and Ms. Cao-C were vigilant about their parents' old age and risk of increasing frailty, which could exceed their family caregiving capacities. However, they excluded their parents from making the decision. Because their parents were relatively healthy, the decision raised the two elders' feelings of abandonment and angst.

The last straw: "We had no choice. They had no choice." Four families (the Lin, Ye, Zhang, and Zhou families) encountered tremendous family caregiving pressure due to elders' health problems before deciding to institutionalize. Caregiving pressure increased suddenly because Mrs. Lin-E and Mrs. Ye-E had accidents. Mrs. Lin-E fell in the shower and had a hip replacement. Mrs. Ye-E told a more detailed story about her accident:

I sprained my right ankle and fell on the street. It was an uneven surface and I tripped. It turned out that my right ankle was fractured. I had a small surgery, but was hospitalized for about a month.

Ms. Ye-C admitted the caregiving burden being excessive after her mother's surgery:

I have heart problems. After her accident, taking care of my mother became even more difficult for me. I thought I might have a heart attack and pass away before she did.

Mrs. Zhang-E and Mr. Zhou-E had chronic conditions that kept deteriorating as they aged, which gradually exceeded their family's caregiving capacities. Mr. Zhou-E realized that family caregiving had become inadequate:

Just before I moved here [the current nursing home], I was very ill. My asthma broke out frequently at night. I had to see doctors every week and I had to be hospitalized almost every month. I needed some special care, as ordinary family caregiving was not enough for me.

Mr. Zhou-C stated that healthcare was the most compelling reason for institutionalization:

My wife and I made the decision after we heard so many recommendations of nursing home care from our neighbors and my father's friends. In particular, the good healthcare services in the nursing home attracted us. We were really worried about my father's health condition. We thought that his condition might improve if he could have some professional healthcare. I asked him if it was possible for him to try it for 1 month to see if he liked the nursing home.

Mr. Zhang-C was frustrated about his mother's deteriorating diabetes:

My mother has had diabetes for over 20 years. However, as she ages, her diabetes is kind of out of control... from traditional Chinese medicine to pills, then to insulin shots. But her blood sugar always fluctuated. I don't know how to handle the situation.

Their lack of medical knowledge and skills further impeded children from providing adequate healthcare for their parents with critical conditions. For example, Mr. Lin-C considered that family caregiving was unsuitable for his mother:

It was impossible for us to be there for a hip replacement patient all the time, to help her to get to the toilet, to bathe, and to do physical therapy.

Besides professional healthcare, already sour intergenerational relationships were another implicit reason for institutionalization. For example, Ms. Ye-C said:

[My mother's] condition was already difficult for me to handle. But I could not stand her attitudes anymore. My mother always treated me as her servant. She became more and more unreasonable after the surgery. It was too much for me. I couldn't take it. Caregiving should be mutual. She should be considerate to me as well.

However, these children admitted that institutionalization was not an easy decision, even though they had encountered excessive caregiving burdens. For example, Mr. Lin-C acknowledged the advantages of institutionalization, though he still preferred family caregiving on the emotional level:

Nursing home care can help my mother's condition. There are professional caregivers who know how to improve my mother's condition. But I don't think staff can provide emotional support like families can. We Chinese like family caregiving no matter what. It's our tradition after all.

In order to avoid adverse reactions from his mother, Mr. Zhang-C suggested institutionalization as a temporary option:

We listed our difficulties taking care of her and told her about our worries. I told her this was a temporary decision. She could always go back home if she wanted to.

In these four families, both generations realized that family caregiving had become inadequate when elders' health conditions continually deteriorated or suddenly worsened. Children had reached their mental and physical limits with demanding family caregiving. Their sense of caregiving depletion became the last straw, calling for resolution to restore caregiving equilibrium.

These four elders reacted differently to their children's decisions. Mrs. Lin-E agreed immediately to institutionalize to reduce her children's caregiving burden. Mrs. Ye-E agreed to institutionalize for her daughter's sake:

I knew that I could not say "No" to her. My son-in-law always complained that my daughter had to take care of me instead of his granddaughter. My daughter had no choice. What could I say? It was my turn to consider her life.

Mr. Zhou-E changed his attitude toward the decision after hearing his friends' experiences in other nursing homes:

I was against my son's suggestion at first. I thought he was abandoning me. But some of my old neighbors told me how they enjoyed the life in the nursing home. Their health improved and they were not lonely any more. This became an encouragement for me to try institutionalization.

Mrs. Zhang-E described her different reactions to being institutionalized twice:

[The first time in a private nursing home] it upset me. But my son told me that there were doctors in the nursing home who could provide healthcare and prescribe medication. I thought that was good enough. [The second time] my son found this nursing home for me. My pension can fully cover my living expenses in this nursing home and the services are much better than the private one. Then I thought "Why bother moving back with my son?" I didn't think too much about my institutionalization. It's just life. I accept whatever life brings me. Now I enjoy freedom and independence in the nursing home.

These four elders accepted their children's decision primarily to compensate their children's caregiving. But their friends' and their own experiences of institutionalization also prompted their agreement.

In these four families, children decided to institutionalize for their parents after their resources were depleted. Initially, their parents were afraid, nervous, and furious about the decision, but they gradually realized that family caregiving was not as dependable as it used to be. Children persuaded their parents by pointing out their difficulties and the advantages of nursing home care. With their children's insistence and their friends' confirmation of its advantages, these four frail elders eventually accepted institutionalization as the next caregiving phase.

Spatially situated decision-making. Figure 4 conceptually generalizes and categorizes the 12 families' experiences of deciding to institutionalize, using a Cartesian coordinate system.

The horizontal axis represents participants' voluntariness in deciding to institutionalize, from reactive decisions to proactive decisions. Proactive decision-making means that elders proposed to institutionalize themselves, or children took precautions to propose institutionalization for their parents. Reactive decision-making means that family caregiving exceeded children's capacities, and they had to seek institutionalization for extra instrumental and/or healthcare support.

The vertical axis represents participants' reasons for deciding to institutionalize, ranging from instrumental needs to psychosocial needs. Instrumental needs related to either generation's deteriorating health conditions. Psychosocial needs related to elders' needs for increasing social interactions and avoiding strained intergenerational relationships.

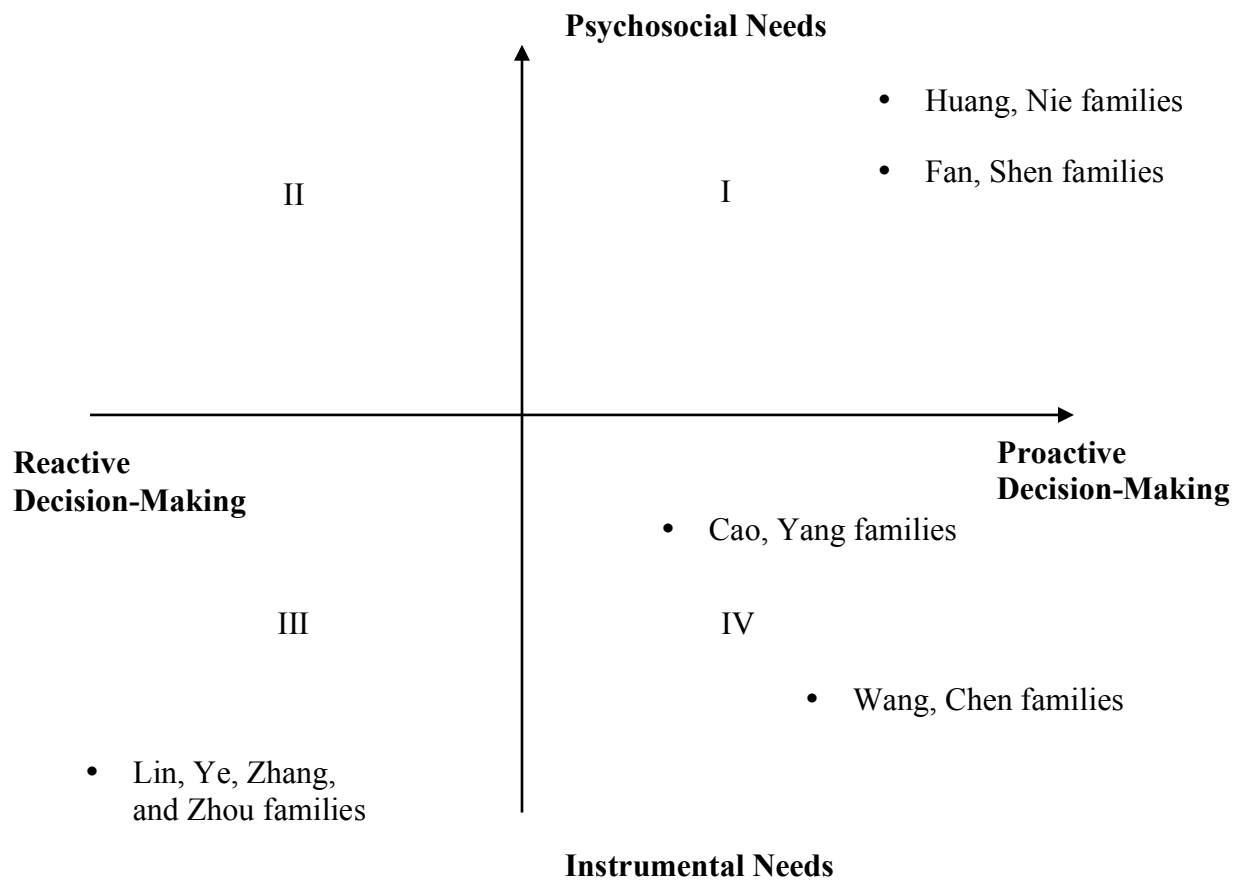


Figure 4. A Cartesian coordinate system of the 12 dyads' experiences of deciding to institutionalize.

Above the horizontal axis, participants were concerned with psychosocial needs, whereas below the horizontal axis, participants emphasized how to face increasing instrumental needs. On the left of the vertical axis, participants focused on coping with collapsing family caregiving. On the right of the vertical axis, participants were vigilant about family caregiving resources and caregiving pressure.

In the Cartesian coordinate system in Figure 4, the 12 families fall into three quadrants. The first quadrant contains four families in which elders decided to institutionalize themselves. Mrs. Fan and Mrs. Shen were healthy elders but increasingly lonely in their homes. They longed for more social interaction in the nursing home. On the other hand, Mrs. Huang and Mrs. Nie were motivated, despite their relatively weak health statuses, to escape strained intergenerational relationships. They envisioned how institutionalization could meet their instrumental and psychosocial needs. Thus, these two groups of families were high in both proactive decision-making and psychosocial needs. Both groups were proactive, but differing in their motivations.

Four families fall into the third quadrant. This group of families represents the predominant reason for deciding to institutionalize. That is, elderly parents' needs exceeded their children's resources. Children decided for their parents to institutionalize to seek extra healthcare and instrumental support. These four families appeared high in both reactive decision-making and instrumental needs.

Another four families fall into the fourth quadrant. Two elders, Mr. Cao and Mrs. Yang, were relatively healthy, yet their children made the decision for them to institutionalize in order to monitor their safety. These two families were comparatively low in both proactive decision-making and instrumental needs. In contrast, Mr. Wang and Mrs. Chen were involved in the decision-making process with their children as their family members' health problems

subsequently impaired family caregiving. These two families were high in instrumental needs, and also comparatively high in proactive decision-making.

In sum, this Cartesian coordinate system categorizes the 12 families' experiences of deciding to institutionalize into three major groups: 1) a proactive decision to meet psychosocial needs, 2) a proactive decision to meet instrumental needs, and 3) a reactive decision to meet instrumental needs. Proactive families were vigilant about potential caregiving pressure that might exceed the children's capacity. Reactive families sought institutionalization after they had encountered tremendous caregiving pressure. Children controlled the decision-making in reactive families. Elders participated in the decision-making process in proactive families. Elders retained decision-making autonomy and resilience in the face of children's pressure to emphasize their increased psychosocial needs in the proactive families, while children emphasized their parents' increased instrumental needs in reactive families.

Au Revoir Family Caregiving

Elders shared some uncertainties about living in the nursing home and hesitated to leave home in both reactive and proactive families. Their children helped them to manage these uncertainties before finalizing the decision.

Different uncertainties. Both generations admitted that institutionalization was a life-changing event for elders. Elders emphasized concern adjusting to life in the new environment. For example, the reason Mrs. Chen-E moved into the nursing home with her husband was that she had to help him adjust to life there. In particular, those elders with weak health were more nervous. For example, Mrs. Lin-E feared that her limited mobility would make it very difficult

for her to adjust to institutional life. Mrs. Zhang-E was nervous about sharing a room with the other resident. Mrs. Ye-E's description generalized all the uncertainties shared by most elders:

The most uncertain... There were so many uncertainties. You know, it's not like living at home any more. It's gonna be difficult. Living conditions are totally different, and I have to share a room with the other roommate. Also, I cannot see my friends often after moving. All in all, I didn't know what to expect.

Besides health and life adjustment issues, elders who were excluded from the decision-making process further worried about their children's abandonment after institutionalization. For example, Mrs. Yang-E said:

The nursing home had been a mysterious place to me. I did not know what to expect. I cannot picture myself at such a place with other childless elders. I thought my children wanted to dump me here.

Mrs. Ye-E had a very depressing perception of nursing homes in general:

Moving to the nursing home was simply to wait for my death... I was too old and too weak and I couldn't see things clearly. I didn't know if my daughter would just dump me in the nursing home and never visit me again. She probably doesn't want me anymore. I would just live in the nursing home and wait.

Deciding to institutionalize itself was an emotionally disturbing process for both generations.

Elders may have felt even more devastated than their children, especially when they were excluded from the decision-making process. Elders felt violated because of their lack of autonomy, and disappointed by their children not honoring the tradition of filial piety.

Children, on the other hand, were concerned about their parents' relationships with staff, which might affect the quality of care. For example, Mr. Lin-C expressed his worry:

I was not sure if my mother would not get along with the staff. I wondered if the relationship would affect the care to my mother. They are not families after all.

Mr. Chen-C shared a similar view, especially when his father's personality became difficult to handle:

I worried about my father's relationship with staff and fellow residents. My father had become more and more stubborn and paranoid, because he was bed-bound for too long. I wasn't sure that he could get along with anyone. I just hoped that my father would not fight with the staff.

Although they chose institutionalization for professional healthcare, most children still worried about the quality of care. They were uncertain about whether the relationship between their parents and nursing home staff would adversely affect their parents' care. This concern may have reflected children's own experiences of family caregiving, in which they had experienced misunderstanding and miscommunication with sick parents.

Mystery disentangled. Children helped their parents to manage the uncertainties of institutionalization primarily by searching for qualified nursing homes for them. Close geographical distance was one of the most important factors for children in deciding on an eligible nursing home. For example, Mr. Huang-C and Mr. Shen-C were aware that their parents did not want to leave familiar neighborhoods. Mr. Zhou-C described his search process:

My wife and I went to many nursing homes, at least 7 or 8, in this district and other districts with easy traffic. I chose this nursing home mainly for its close distance and its good service.

Ms. Wang-C went through a similar search process:

My husband and I visited about 10 nursing homes after I was discharged from the hospital. We went to all the nursing homes listed in the telephone book in this district... We narrowed it down to two nursing homes. One was this one, and the other was comparatively farther away. So we decided on this one.

Besides close geographical distance, children specifically attended to the quality of care. For example, Ms. Nie-C said:

Several of my colleagues told me that their parents or in-laws were living in this nursing home and they considered the services really good. I came here and checked the room, the service, the food and the healthcare several times before deciding to send my mother here.

Children chose the current nursing home also because it fit their parents' preferences. For example, Ms. Cao-C identified her father's hygiene requirement:

My father was very neat. I knew he would like to move into a nursing home with excellent hygiene. So I selected this nursing home.

Mr. Fan-C decided on this nursing home, considering his mother's interests:

Besides the good healthcare services, this nursing home offers interest groups, among which there is a Shanghai opera group. My mother loves listening to Shanghai opera. I thought she could continue her hobby in the nursing home.

Once they decided on this nursing home, some children brought their parent to check out the services themselves before the actual institutionalization. For example, Mr. Yang-C brought his mother to the nursing home to check out her future room before he signed the paperwork. Mr. Wang-E recalled his visit in detail:

My daughter and son-in-law brought me here. I remember my first impression was clean. I also watched several staff working. I even tried the lunch that time. I liked the food. I was very satisfied with my daughter's decision. So I moved in here not long after my visit.

Thus, children took various factors into consideration in choosing the current nursing home for their parents, including distance, service quality, and their parents' preferences, in order to reduce their parents' uncertainties about institutionalization. Several elders checked the current nursing home out before their children finalized the decision.

The following and final chapter will address the findings and other elements of this study in detail, discuss contributions of the findings to existing literature, and propose relevant implications for long-term care policy and social work practice.

CHAPTER VI

Discussion and Conclusion

This chapter interprets the findings of this study. First, it will summarize the overall findings. Second, it will revisit the three propositions presented in Chapter III to discuss the theoretical implications of the study findings. Third, it will situate participants' experiences of deciding to institutionalize in the context of filial piety. Then it will examine the phenomenological approach in this study. Finally, it will present relevant policy and social work practice implications, study limitations, future research, and a conclusion.

Participants' Experiences of Deciding to Institutionalize

The 12 families in this study experienced diminishing family caregiving capacity and subsequently encountered caregiving crises. Each generation proactively or reactively faced these caregiving crises and sought institutionalization. Implicitly, in doing so, they may have expected to restore caregiving equilibrium. Age, family caregiving context, caregiving crises, and each generation's perceptions of nursing home care have different relationships with this decision-making process.

Age-distinctive decision-making dynamics. Each generation's perspectives on decision-making will inherently vary because of their age difference (Williams & Harwood, 2004). In this study, each generation held a distinct stance when deciding to institutionalize, suggesting that age differences inevitably emerge in caregiving decision-making (Meisner, 2012).

Among the proactive dyads, elders decided to institutionalize primarily for more peer support and less loneliness in the nursing home. This may relate to their distrust of their children's practice of filial piety and disrupted caregiving arrangements during co-residence.

These elders' positive expectations of institutionalization suggest that engaging with peer groups may give elders a greater sense of psychological comfort and social identification than staying at home alone (Knight, Haslam, & Haslam, 2010; Cheng, 2009).

Despite reaching consensus, children expressed mixed attitudes toward their parents' decision to institutionalize. On the one hand, children had to comply with filial piety by respecting their parents' decision (Chen, 2011). They wanted to compensate their parents for discordant family caregiving with better care in the nursing home. On the other hand, children realized that institutionalization had not yet become a socially-preferred long-term care option, and they might be under pressure from filial piety. Despite their ambivalence, children ultimately accepted their parents' decision.

Compared with their parents, children decided to institutionalize mainly for the extra support of providing assistance with ADLs. Children responded to the increasing family caregiving pressure by seeking paid help, especially professional healthcare for medical needs. Under these circumstances, children favored deciding for their parents. Not including their parents in the decision-making, however, may have caused additional emotional disturbance and resistance by their parents.

Regardless of their parents' health conditions, children, in general excised decision-making power from their parents. For example, two children decided to institutionalize their parents, despite their stable health conditions, in order to proactively prevent depleting resources later. Children's age-stereotyped decision-making may have negated their parents' remaining independence and even inadvertently encouraged dependence (Williams & Harwood, 2004).

When making the decision, children also emphasized their siblings' instead of their parents' opinions. For example, several children had family conferences with their siblings to

discuss the decision. Possibly, they shared mutual understandings of the increasing caregiving pressure, so they jointly decided for their parents (Zhan, Liu, & Guan, 2006).

However, children's decision to institutionalize provoked their parents' strong feelings of intergenerational ambivalence. Intergenerational ambivalence refers to the simultaneous mixture of harmony and conflicts in intergenerational relationships (Guo, Chi, & Silverstein, 2013; Lüscher, 2002). The "simultaneous mixture" in this definition avoids oversimplifying intergenerational dynamics as a dichotomy between harmony and conflicts (Guo et al., 2013; Lüscher, 2002).

In this study, intergenerational ambivalence was manifested when elders opposed their children's decision at first and then, gradually accepted it with continual persuasion from their children. Similar intergenerational ambivalence exists among elders who experience life-changing circumstances and cultural discordance in family relationships in China, Japan, and the United States (e.g., Guo et al., 2013; Traphagan, 2010; Lewis, 2008). In fact, elders in this study emphasized ambivalent feelings when their sons decided for them. This may be due to the contradictory feelings of their preferences for sons and their disappointment about sons' decision to institutionalize. Such contradictory feelings indicate that intergenerational ambivalence consists not only of affection but also simultaneously of disappointment (Guo et al., 2013).

Intergenerational ambivalence is also relevant to elders' feelings of obligation to their children. When their health conditions became frail during co-residence, elders were willing to institutionalize in order to compensate for their children's caregiving up until that point. This pattern corroborates previous findings in another study (Chen, 2011). This feeling of obligation coincides with elders who agree to institutionalize to minimize the burden for their children in Western countries (Cahill, Lewis, Barg, & Bogner, 2009; Reamy, Kim, Zarit, & Whitlatch,

2011). Elders also accepted their children's decision to institutionalize to avoid conflicts and to keep a harmonious atmosphere in the family (Li, Long, Essex, Sui, & Gao, 2012). In Chinese culture, relationship harmony supersedes self-esteem for elders (Fung, 2013). Future qualitative research should explore such nuances of intergenerational ambivalence in caregiving arrangements for Chinese elders.

Progressive and conventional family caregiving. The implications of socioeconomic development in urban China include the intertwining conventional and progressive aspects of family caregiving. First, the gender roles in family caregiving remain traditional. Daughters and daughters-in-law continued to undertake the actual caregiving responsibilities but within the rubric of a patriarchal tradition. Although traditionally, women in both Western and Chinese societies have shouldered most of the caregiving responsibilities (Liu, Dong, & Zheng, 2010; Merz et al., 2009; Whyte, 2004), in East Asian countries daughters-in-law take the primary caregiving responsibility compared to wives in the United States (Nishi et al., 2010).

Surprisingly, a pattern of elders identifying sons as their primary caregivers occurred even though their daughters or daughters-in-law provided the actual caregiving described in their interviews. Two other recent surveys on family caregiving in urban China found that daughters-in-law still represent the largest number of family caregivers (Zhan, Feng, Chen, & Feng, 2011; Zhan et al., 2006). However, these two studies did not distinguish the identification of primary caregivers from those actually providing care. In the current study, elders may have identified their sons as primary caregivers, regardless of who provided the actual caregiving, because their sons arranged their caregiving and co-residence.

The gender roles remain traditional in caregiving decision-making with sons favored over their sisters. When sons made the final decision to institutionalize their parents in the current

study, daughters still may have performed the actual caregiving responsibilities. Perhaps, daughters expressed reluctance to institutionalize (Zhan et al., 2006). Regardless, this study buttresses the strong relationship between a patriarchal tradition and caregiving arrangements in urban China (e.g., Guo et al., 2013; Liu et al., 2010).

Second, elders' relationships with their children-in-law continue to have ample tensions, in particular, with daughters-in-law. Elders considered being taken care of by daughters-in-law as a "penalty" of their surviving (Nishi et al., 2010). For example, female elders criticized their daughters-in-law for not taking good care of them during co-residence. However, caring for parents-in-law negatively associates with employment and hours of work for daughters-in-law in urban China (Liu et al., 2010). This finding echoes previous research showing that caregiving arrangements relate to common mother-in-law/daughter-in-law tensions (Liu et al., 2010; Nishi et al., 2010; Gu & Vlosky, 2008; Zhan et al., 2006).

Third, co-residence, in accordance with filial piety, remains the primary type of family caregiving. All participating elders lived with their children prior to institutionalization. Their children, namely sons, asked them to live with them after their widowhood, especially when their health conditions deteriorated. Elders' widowhood (Frankenberg, Lillard, & Willis, 2002) and elders' functional limitations (Zimmer & Korinek, 2008) commonly activate co-residence.

Finally, exchanging property for children's caregiving represents an emerging trend for elders to ensure family caregiving in urban China (Wang, 2010); this contrasts with filial piety (Cong & Silverstein, 2011). The acceptance of property by children becomes an implicit agreement and commitment between generations. Unlike the Family Support Agreement policy requiring children's care for elderly parents in rural China (Chou, 2011), this exchange compensates for and preventively secures children's family caregiving. Perhaps, elders feel safer

than passively expecting children's care. Further, elders in urban China have more financial resources than their rural counterparts, thus, enabling them to use financial incentives for ensuring children's caregiving.

Ironically, in this study, exchanging property for caregiving did not necessarily guarantee family caregiving. This implicit contract could be revoked because of unforeseen issues like a child's own health problems. In other cases, children withdrew their caregiving when they expected the property but did not receive the "payment." Future research should explore such discordance in intergenerational expectations about property exchanges in relation to caregiving arrangements.

Sudden onset and cumulative family caregiving crises. The findings suggest two types of changes may contribute to family caregiving crises: sudden onset and cumulative. Sudden onset caregiving changes are often related to elders' accidental falls or emergent illnesses. When elders' needs for healthcare suddenly escalated, they may have exceeded their children's caregiving capacities (e.g., Chen, 2011; Sprangers et al., 2002; Schulz et al., 2000). Children's health problems and accidents also contributed to sudden onset caregiving changes. However, children's health problems did not necessarily lead to their parents' immediate institutionalization. Instead, their parents' caregiving arrangements may first have been transferred among siblings. The reliance on siblings to share caregiving responsibilities often occurs in those families with multiple children (Zhan & Montgomery, 2003), which is particularly true for Chinese baby boomers (Fong, 2004).

Besides sudden onset illness, elders' chronic conditions were major contributors to cumulative changes in family caregiving in this study. As elders continued to age, their chronic conditions kept deteriorating and increased their needs for both custodial and skilled healthcare.

Children's lack of medical knowledge made it additionally difficult for them to provide proper caregiving. Their own ongoing and emergent constraints further complicate caregiving situations (Talley & Montgomery, 2013; Bevans & Sternberg, 2012). Also, children age, too. Children reported that they could barely keep up with their parents' worsening health conditions with their own declining abilities. Both generations' maturational changes became obstacles for children to provide adequate family caregiving.

Co-residence also contributed to cumulative changes in family caregiving. During co-residence, strained relationships with children-in-law, different lifestyles between generations, and unsuitable living conditions all provided a base for subsequent changes in family caregiving, which eventually created caregiving crises. These disadvantages of co-residence, in particular, related to elders' motivations to institutionalize. When they felt frustrated and unwelcomed in children's homes, elders would either make their own caregiving decision or accept their children's decision to institutionalize. A recent survey in Shanghai supports these patterns, because elders' satisfaction with children's support was found to be negatively associated with elders' intention to institutionalize (Chen & Ye, 2013). Future research should examine the relationship between co-residence and elders' intention to institutionalize in community settings.

Positive and negative perceptions of nursing home care. Each generation experienced different uncertainties about institutionalization during the decision-making process. Elders were distressed and anxious about the subsequent life adjustment. Children worried about their parents' relationships with the staff, which might influence their quality of care.

Elders from reactive families held negative perceptions of nursing home care as only appropriate for childless and extremely poor elders. This reflects the stigmatized impressions of nursing home care that have been ingrained in the Chinese society (e.g., Feng et al., 2011b; Chu

& Chi, 2008; Zhan et al., 2008). The lack of viable long-term care options may be another reason for elders to favorably consider family caregiving (Li et al., 2012; Cheung & Kwan, 2009). However, elders familiar with nursing home care may be more open to institutionalization (Wang, Laidlaw, Power, & Shen, 2009).

Children may have interest in institutionalization because of low resources. In fact, declining ADLs and IADLs and increasing caregiving pressure present primary motivations for institutionalization in the United States and Asia (e.g., Wattmo et al., 2011; Chang & Schneider, 2010; Ishii-Kuntz, 1997). However, elders also considered their health conditions stable, negating the need for institutionalization. This discrepancy suggests that children and elders perceive caregiving needs and resources differently. Future research should explore these different generational perceptions in how they influence the decision to institutionalize.

In sum, old and young ages, traditional and evolving family caregiving contexts, sudden and cumulative caregiving crises, as well as positive and negative perceptions of nursing home care coexist and intertwine in the decision-making process around institutionalization for both generations.

Filial Piety and the Decision to Institutionalize

With the socioeconomic development in urban China, participating elders and their children conveyed different perceptions of filial piety, its associated morality, and practice in reality. These discrepancies in relation to caregiving arrangements and expectations may lead to misunderstanding, resentment, or conflicts between generations (Kim, Zarit, Eggebeen, Birditt, & Fingerman, 2011).

Elders in this study maintained high standards of filial piety. When they received family caregiving as they expected it, elders praised their children for honoring filial piety. However, when their expectations were not met, they felt entitled to receive more care and viewed their children in violation of filial piety. After having disrupted family caregiving and/or being bounced among children, elders noticed a withdrawal of family caregiving and emotional attachment. Emotional connections may have more meaning to elders than instrumental support. When children prioritize the latter, elders may be increasingly dissatisfied.

Elders' nostalgia for filial piety may arise from internalized Chinese cultural beliefs that encourage adherence to norms and traditions across the life span (Fung, 2013). The older generation holds traditional cultural values more closely than the younger generation (Ho, Fung, & Tam, 2007). Age, in particular, may even reinforce elders' steadfastness to tradition (Ho et al., 2007). Not surprisingly, when their children adhere to filial piety, Chinese elders perceive their caregiving favorably (Li et al., 2012). However, some elders understood the evolvement of filial piety relating to socioeconomic development. Accordingly, they adjusted their caregiving expectations and accepted their children's decision to institutionalize. This finding suggests that elders in urban China recognize a discrepancy between filial piety as an ideal and the reality of caregiving and its costs (Li et al., 2012).

In contrast to their parents, children admitted that they could not fully comply with filial piety. With increasing demands, filial piety became less practical. Seeking practical resolutions outweighed abiding by filial piety for children. In order to allay their parents' loss of family caregiving, children sought a wide range of nursing homes. This extensive search process may have represented a feeble attempt at maintaining filial piety to minimize their parents' imminent grief. Still, though, given the limited options, children considered institutionalization the only

long-term care option (Chen & Ye, 2013; Zhan et al., 2011; Chen, 2011). Clearly, children face a looming dilemma: being perceived as socially immoral if they violate filial piety or risking their parents or their own well-being if they follow filial piety. In other words, filial piety may become less practical over time.

Furthermore, the emotional component of filial piety may become negligible. Assistance with ADLs or IADLs may occur disproportionately at the expenses of emotional support, because children prioritize the former. Children seemingly considered the professional healthcare of nursing homes as offsetting declining emotional attachment and instrumental support at home. Adult children with limited resources (e.g., medical knowledge) or competing demands (e.g., their own children and/or work) may increase instrumental support to minimize their own feelings of guilt about decreasing emotional support (Lin, 2008). This paradox may explain the existence of cautious optimism that filial piety will survive, and Chinese elders will remain supported (Korinek, Zimmer, & Gu, 2011). That is, children did still value filial piety and its corresponding emotional and instrumental support but they could not continue to provide simultaneously.

In addition, belonging to the first cohort of Chinese baby boomers affected children's perceptions of filial piety. Born in the 1950s and 1960s, these children's identities and experiences, arising from a series of significant historical events and policy changes across their life courses, played a critical role in shaping their perceptions of long-term care and family caregiving (Liang, 2011). These children did not believe in filial piety as strongly as their parents. They realized that their own children would not have any siblings to whom they could transfer caregiving burdens. They believed that various types of long-term care, especially nursing home care, might provide their caregiving needs. A phenomenological study on Chinese

baby boomers' attitudes toward their own aging supports this assertion; baby boomers accept the need to reduce expectations for filial piety in later life (Liang, 2011).

In all, filial piety remains an integral but dynamic part of family caregiving and the decision to institutionalize in urban China, though it in the purest sense may be declining in general (Korinek et al., 2011). Children acknowledge the availability and practicality of caregiving alternatives.

Theoretical Implications

Chapter III included three propositions based on crisis theory, social identity theory in intergenerational communication, and uncertainty management theory (UMT) to help conceptualize participants' experiences of deciding to institutionalize. The study findings support some parts of the propositions, while they challenge others. Table 6 presents a summary of modified propositions following by a detailed discussion.

Table 6

Three Modified Propositions

| Proposition | Theory | Before the Study | After the Study |
|--------------------|---------------------------------|--|---|
| 1 | Crisis Theory | Caregiving crises may initiate the decision-making process around institutionalization between generations. | For reactive families, caregiving crises directly initiate intergenerational communication about the decision to institutionalize. For proactive families, potential caregiving crises motivate the decision. |
| 2 | Intergenerational Communication | The younger generation may have greater capacity to make the decision. | In general, children lead the decision-making even though elders may maintain decision-making capacities. |
| 3 | Uncertainty Management Theory | Each generation may conceptualize caregiving uncertainties differently related to the decision to institutionalize, and intergenerational communication influences the management process. | Both generations share some uncertainties, but different perceptions of nursing home care also exist. Children help their parents to manage uncertainties not only by intergenerational communication, but also by involving their parents in the actual selection process. |

Crisis theory. First, each generation conceptualized and approached caregiving crises differently. Children reported that their needs for extra assistance with instrumental and medical support fueled caregiving crises. Elders, however, felt that the strained intergenerational relationships might have been the culprit, including conflicts with children or children-in-law, disrupted caregiving arrangements, and undesirable co-residing conditions. Such a wide range of strains indicates that elders have broad caregiving expectations for their children.

Second, both generations recognized that caregiving crises were not necessarily sudden onset. Any changes in existing caregiving patterns could lead to a potential caregiving crisis (Schulz, et al., 2000; Levy-Storms, 1996). In this study, children admitted that their parents' continuous health deterioration, rather than sudden accidents, seriously challenged their abilities to provide sufficient and proper family caregiving. Children's own constraints contributed to caregiving crises; their own declining stamina prevented them from providing adequate caregiving for their parents and motivated consideration of nursing home care. They, too, expressed awareness of strained intergenerational relationships during co-residence as an important factor.

The findings in this study suggest that caregiving crises can trigger families' decision to institutionalize. These crises directly relate to family members' appraisals of caregiving situations and their adaptive abilities as well as to their consideration of caregiving alternatives. Future research should further pursue insight into how the discrepancies in conceptualizing caregiving crises between generations influence their divergent understandings of initiating, negotiating, and finalizing caregiving decisions.

Intergenerational communication. As social groups tend to be classified by age, elders and their children become two opposite social groups in their intergenerational communication.

Participants fell into different groups by 1) intergenerational social identity and 2) intergenerational communication accommodation.

Intergenerational social identity. Social identity theory (SIT) argues that people classify themselves as similar to or different from members of other groups as well as being superior or inferior (Tajfel & Turner, 1986). The dynamics of intergenerational communication reflect each generation's negotiation of their own identities in the context of age relations (Williams & Harwood, 2004).

Children seemed “superior” to their parents in the decision-making process in that they assumed themselves more knowledgeable about nursing home care than their parents. That is, children justified their decision to institutionalize based on the healthcare it provides, while purporting that their parents had limited knowledge of nursing home care. Furthermore, children were more vigilant about responding to family caregiving crises than their parents, as they proposed to institutionalize when they realized caregiving resources might soon be depleted. For example, two children in this study took precautions to avoid potential caregiving crises, because they believed that their parents were too frail to foresee the potentially increasing caregiving burdens.

Compared with their children, elders seemed “inferior” in intergenerational communication in this study. This is particularly true for elders from reactive families. Their declining physical capability of taking care of themselves increased their dependence on their children and their feelings of obligation to their children, which in turn, decreased elders' decision-making autonomy. They felt powerless to face the changes in caregiving arrangements, given their frailty.

Overall, the findings in this study align with SIT in that elders played a seemingly inferior role compared to their children during intergenerational communication about institutionalization. Future research should explore the relationship between elders' health conditions and their identity in intergenerational communication about their caregiving decision-making autonomy.

Accommodated intergenerational communication. Social identity manifests in communicative behaviors (Barker et al., 2004), and, as such, one must examine how each generation communicates about deciding to institutionalize. Communication accommodation theory (CAT) can help to analyze these behaviors. This theory describes and explains aspects of how individuals adapt their speech in an interactive way (Williams & Nussbaum, 2001). In other words, how individuals express themselves in social situations changes according to the conversational participants and influential contextual factors.

Two forms of accommodating behaviors exist in intergenerational communication: over- and under-accommodation (Williams & Nussbaum, 2001). Over-accommodated communication means that the younger generation patronizes the older generation by using “slower speech, exaggerated intonation, higher pitch, repetition, vocabulary simplification, and reduced grammatical complexity” (Fox & Giles, 1993, p. 433). For example, some children mentioned that they used “elderspeak” to over-accommodate their parents to show that they were being considerate when discussing the decision to institutionalize.

Under-accommodation means that the younger generation neglects to be sensitive to the conversational needs of the older generation (Fox & Giles, 1993). For example, some sons in this study under-accommodated their parents in caregiving arrangements. They made their caregiving

decisions without consulting their parents or simply ignoring their parents' strong emotional attachments to family caregiving.

The findings in this study suggest that under-accommodated intergenerational communication may occur, because children focus more on reducing their own caregiving pressure than on meeting their parents' actual emotional and instrumental needs. This reflects how filial piety in urban China may be evolving to favor reducing children's caregiving burden (Chen, 2011; Wang, 2010). Another reason may be that participating elders were cognitively intact. Their children may have thought that they were mentally competent and fully aware that the decision to institutionalize would be beneficial to both generations. Ironically, this belief may have helped to *preserve* their parents' autonomy by making them work harder to communicate. Also, children's under-accommodated conversations can help minimize elders' identity with being old, which elders may consider positive (Westerhof, Whitbourne, & Freeman, 2012).

However, children's under-accommodated communication could induce elders' ambivalent feelings. For example, some elders in this study criticized the condescending ways that children conveyed the decision to institutionalize. Children's under-accommodated communication counters what filial piety promotes: children should practice filial piety willingly and freely (Cheung & Kwan, 2009). Children's condescending attitudes may have raised elders' questions about the genuine nature of their children's caregiving. Their resulting disappointment may have made elders anticipate the possible abandonment and may have prompted them to abide by their children's decision to institutionalize.

Thus, CAT captures over- and under-accommodated intergenerational communication about the decision to institutionalize. Elders' health conditions contribute to children's choice of over- or under-accommodated conversational styles. The weaker the elder is, the more over-

accommodated their children would be. Although children's under-accommodated conversations treat their parents as equal partners, elders may still feel ambivalent towards their children's decision.

Discrepancies in communication contents. Resulting from various concerns, discrepancies may exist between generations' descriptions of their experiences of deciding to institutionalize. Examples of discrepancies included those around property exchanges, intergenerational relationships, and caregiving arrangements. These discrepancies imply different motivations to institutionalize for each generation.

Admittedly, each generation's versions of their experiences of deciding to institutionalize differ based on individuals' perspectives, but each generation may also have masked their true motivations to institutionalize. Each generation may have presented the version that most favored themselves, to preserve their positive social identity in the interview. In particular, children may have been diplomatic by avoiding talking about strained intergenerational relationships, because filial piety requires that children not complain about their parents' decisions or behaviors (Chou, 2011). Elders, however, more openly discussed their complaints about their children's caregiving. This reflects elders' beliefs that their children should reciprocate everything that their parents did for them (Bian et al., 1998). It may also be because elders do not consider caregiving arrangements as a private matter as their children do, as they have already accepted the decision and have made the transition to the nursing home.

Therefore, the findings in this study support SIT and CAT. Both generations respectively strove for positive social identity in intergenerational communication, perhaps to enhance their individual stance when deciding to institutionalize.

Uncertainty management. Before finalizing the decision to institutionalize, both generations experienced uncertainty. Most of their uncertainties related to life changes in the nursing home—the very social uncertainties categorized by UMT (Hogan & Brashers, 2009).

In order to manage these social uncertainties, most children in this study engaged in information seeking, appraisal, adaptation, and reappraisal (Hogan & Brashers, 2009). First, children collected information and searched for qualified nursing homes. They took geographical distance, quality of care, food, roommate issues, and so forth into consideration. Then they checked the services in the nursing homes several times before their parents moved. Finally, children evaluated each eligible nursing home and finalized the decision with their siblings and/or their parents.

However, in contrast to UMT, most children did not reevaluate the decision after their parents moved. Although some of the elders had the opportunity to check the nursing home before actually moving, most of them still accepted the decision regardless. Still, other elders had reevaluated the decision when they had lived in private nursing homes and had not been pleased with the quality of care or high fees.

Besides these actual search processes, intergenerational communication also contributed to managing uncertainties by emotionally preparing elders for the life-changing event. Almost all the children in this study listed the advantages of nursing home care to persuade their parents. Elders' requirements for institutionalization also helped to reduce their uncertainties and to assure some of the living conditions in the nursing home.

Indeed, not all children and elders had uncertainties about institutionalization. The proactive families did not worry about life in the nursing home, because they were familiar with it. Furthermore, other elders had not been concerned about institutionalization, because they

trusted their children's choice. Still others were not concerned about institutionalization, because they had checked the current nursing home before finalizing the decision.

In all, the findings in this study partially support UMT. Most families went through the appraisal and adaptation phases but not necessarily reappraisal. Besides searching for qualified nursing homes, children also eased their parents' uncertainties about institutionalization by preparing them emotionally via intergenerational communication. Future research should explore specific uncertainty management stages around institutionalization to determine how intergenerational differences may propel or impede the decision to institutionalize.

In sum, the conceptual framework captured participants' experiences of deciding to institutionalize by integrating crisis theory, SIT, CAT, and UMT. Caregiving crises triggered intergenerational communication on deciding to institutionalize. Each generation retained a positive social identity and a "superior" position in the communication. However, children showed greater power by accommodating their parents in the conversations to reach consensus. Children helped their parents to manage the uncertainties about institutionalization to finalize the decision, even though not all of them worried about this life-changing event for their parents.

Methodological Implications

Phenomenological reduction. The author followed Husserl's (1970) descriptive phenomenology principles in this study (Creswell, 2007). The method remained consistent with the descriptive phenomenological orientation in this study, which was critical for maintaining methodological clarity (Miles & Huberman, 1994).

The author systematically applied the Moustakas (1994) approach to enhance phenomenological reduction and to address potential criticism of phenomenology as typically

unclear (Bevan, 2007; Creswell, 2007). The author performed phenomenological reduction by exploring intentionality and examining typifications—individuals' used to construct their familiar world—to discover the essence of their experiences of deciding to institutionalize.

Intentionality of the decision to institutionalize. Elders' intentionality in the decision to institutionalize changed slowly but dramatically. Before caregiving crises, elders saw their children's caregiving as aligned with filial piety, but they noticed that children's caregiving became inadequate. Encountering family caregiving crises led to elders' realization that family caregiving may have reached or was near reaching its limits. As a result, they began to question their strong beliefs in filial piety. Gradually, they suspended their old beliefs and attempted to establish a new understanding of family caregiving and long-term care. Their reluctant acceptance of the decision to institutionalize subsequently followed.

Compared with their parents, children's intentionality in the decision to institutionalize changed rapidly. Children had less time to consider their beliefs in filial piety, because they had to react quickly to family caregiving crises. So they quickly suspended their beliefs in filial piety and did not hesitate to seek alternatives to confront declining family caregiving resources, though they remained keenly aware of their parents' traditional caregiving expectations.

Thus, participants' intentionality in deciding to institutionalize became their means of conceptualizing and making sense of what they experienced during changes in family caregiving (Biehl et al., 2007). Their intentionality evolved over the decision-making process, albeit at a different pace for each generation.

Intergenerationally divergent typifications. Participants' typifications of filial piety, family caregiving, and nursing home care transformed during the decision-making process. Elders typified filial piety as a holistic concept, emphasizing both instrumental support and

emotional support. Children's typification of filial piety became limited to instrumental support in order to alleviate family caregiving burdens and at the cost of emotional support.

Elders' typification of family caregiving remained exclusively within families. However, children's typification of family caregiving broadened. They considered institutionalization a form of family caregiving as long as they still visited their parents in the nursing home. Children's insistence on utilizing different types of caregiving to meet their parents' various needs challenged filial piety.

Elders' typification of nursing home care transformed dramatically during the decision-making process, especially for those who were from reactive families. Since they were not childless but being institutionalized suggested their becoming "childless, extremely poor elders" (Wong & Leung, 2012), these elders were angry at their children's decision. In other words, they may have "bought into" the deeply rooted, stigmatized image that Chinese people had of those who live in nursing homes. After their children explained the reasons for institutionalization and brought them to visit the nursing home, elders gradually understood that nursing home care might be able to provide what their children could not: assistance and medical care. In contrast, children's typification of nursing home care remained consistent throughout the decision-making process. They accepted nursing home care as one of the viable long-term care choices for sustaining extensive healthcare for their frail parents.

Thus, participants voluntarily or passively suspended the old typifications of filial piety, family caregiving, and nursing home care. During the decision-making process, they accepted salient information and reconstructed new typifications. This evolution matched their emerging intentionality during the process. When both generations gradually came to share increasingly similar views on these typifications, the intergenerational discrepancies reduced. Accepting a

common system of typifications led to a homogeneous understanding between generations (Wagner, 1970).

A dyadic perspective. This study emphasizes a dyadic perspective to analyze the decision to institutionalize. As decision-making is social and interactive in nature (Carroll, Mollen, Aldridge, Hexem, & Feudtner; 2012; Williams & Nussbaum, 2001), it is difficult to view either generation separately during the process. The dyadic perspective highlights the relational aspects of how both generations communicated with each other to reach consensus on institutionalization.

Both generations exchanged their perspectives on intergenerational relationships, family caregiving, and institutionalization during the decision-making processes. For example, elders expressed their concern about life adjustment in the nursing home, so their children made an effort to search for a qualified and affordable nursing home to reduce their parents' concern. From their children's descriptions of nursing home care, elders began to realize that they were still able to preserve some independence in later life by institutionalizing. Such interaction helped both generations to acknowledge and accept, willingly as well as unwillingly, each other's views on caregiving arrangements and, eventually, to reach consensus on institutionalization. These underlying linkages might not have been identified if these conversations had been analyzed separately.

Researchers' bracketing experiences. Schutz (1970) asserts that the first step of descriptive phenomenology is to bracket all preconceived notions. This requires researchers to eliminate all the assumptions related to the phenomenon of interest by disconnecting from them (Koch, 1995). The disconnection means that the researcher suspends all beliefs in past knowledge associated with the phenomenon (i.e., bracketing; Kockelmans, 1994). This allows

for an exclusive focus on the participants' descriptions to provide insight to researchers (Creswell, 2007).

The author bracketed her own understanding and experience of the decision to institutionalize, filial piety, family caregiving, and familial decision-making dynamics through several steps. First, she respected everything that participants conveyed and encouraged them to describe their experiences in detail during the interviews. She was attentive to accepting and recording all the information from participants and taking nothing for granted.

Second, the author took a critical stance (i.e., epoché) of her own stock of knowledge of the phenomenon. Keeping a reflexive journal during data collection and writing memos helped her to self-question when she had concern about bringing her own opinions into the interviews and data analysis. The journal and memos also provided an audit trail to allow for repetition of the study by another researcher (Patton, 2002).

Finally, the author emphasized a dyadic perspective in data analysis, in order to avoid potential biases leaning toward either generation. For example, intergenerational communication, a crucial component of this study, was studied dyadically to avoid judging which generation was right or wrong.

Research, Practice, and Policy Implications

Implications for caregiving decision-making research. First, this study establishes a conceptual framework to capture the decision-making process around institutionalization among elders and their children in urban China. This conceptual framework helps to analyze how, when, and under what circumstances this decision may occur. This process involves the original family caregiving context, family caregiving crises, intergenerational communication, uncertainty management, and finalizing the decision to institutionalize. Examining these elements may help

the younger generation to know when they need to take actions to face family caregiving crises and seek caregiving alternatives before family caregiving reaches its limits. It is also meaningful to the older generation to emotionally prepare for instrumental support from people other than their children, such as nursing home staff. However, this conceptual framework needs further testing in future research.

Second, this study captures a silhouette of the evolution of filial piety and its role in the decision to institutionalize. Children currently consider filial piety impractical, while elders' reminiscence of filial piety continues to influence their caregiving expectations. This intergenerational discrepancy indicates that while filial piety has evolved for all generations in urban China, its historical roots remain deeply ingrained in one way or another among different generations. Future investigation on filial piety may need to characterize its longitudinal changes since the Economic Reform.

Implications for social work practice. Recent evidence suggests health assessments, care planning, coordination of and support for decision-making, adjustment to long-term care, resident advocacy, and family communication as essential components to social workers' roles in long-term care (Koenig, Lee, Fields, & Macmillan, 2011; Berkman, Gardner, Zodikoff, & Harootyan, 2006). This study provides insight into all of these aspects.

First, this study can help to establish detailed needs assessment criteria for specialized long-term care services in urban China. As the current needs for long-term care of elders are mixed in urban China (Feng, Liu, Guan, & Mor, 2012), detailed needs assessment criteria can help target specific needs and link them with suitable services (e.g., available community-based services vs. simple institutionalization). Furthermore, detailed needs assessment criteria can facilitate social workers to provide individualized caregiving and improve resident advocacy. For

example, social workers can pay special attention to residents that may feel particularly abandoned and distressed about their children's decision to institutionalize.

Second, this study can help to improve families' communication with social workers and staff in the nursing home. Families and staff often have negative stereotypes of one another, leading to mutual distrust and disbelief (Pillemer et al., 2003). Poor relationships between families and staff can lead to anxiety and stress on both sides related to caregiving for elders (Pillemer et al., 2003). This study highlights the importance of intergenerational communication to facilitate better understanding of caregiving expectations and caregiving arrangements between elders and their children. Improved communication and understanding can allow children to convey their parents' preferences and life habits to social workers and staff in the nursing home, which may help to avoid misunderstandings in the overall caregiving relationships.

Third, this study can help to maintain elders' autonomy in caregiving decision-making. It is important to know whether and how elders would prefer their children to participate in the decision-making about their caregiving arrangements, either in the moment as needed or in the future by documenting elders' preferences should the need arise. Despite their declining health conditions, more elders would like to maintain their decision-making autonomy under the influences of the Economic Reform, which has advocated individualization and decentralization of Chinese health care (Guan, Zhan, & Liu, 2007; Leung, 2005). Future research can investigate how social workers may protect elders' self-determination during the institutionalization process in order to protect elders' remaining decision-making autonomy.

Finally, this study can help to strengthen knowledge-based training programs for social workers. The lack of training for social workers has impeded the quality of caregiving service and the development of long-term care in urban China (Feng et al., 2011a; Chu & Chi, 2008).

Firsthand knowledge of the decision-making process around institutionalization can enhance frontline social workers' understandings of the family dynamics regarding caregiving decision-making dynamics and the caregiving expectations of both generations. Future research needs to highlight the urgent needs for training, practice, and monitoring of frontline social workers, as well as establishing practice guidelines based on such firsthand knowledge.

Long-term care policy development in China. The growing aging population and fragmented care system have challenged the current long-term care system in urban China (Feng et al., 2011b; Chu & Chi, 2008; Gu & Vlosky, 2008). This study may inform the nascent Chinese long-term care policy at a critical point when the society faces the inevitably and increasing challenges of providing care to elders.

Although the Chinese Ministry of Civil Affairs decided to strengthen long-term care services for the aging population in its 12th five-year plan (2011–2015; Ministry of Civil Affairs, 2012), services still carry an institutional bias by targeting those childless elders with extremely low income or with disabilities (Feng et al., 2012; Wong & Leung, 2012). Elders with children continue to expect family support, regardless of their health conditions and/or children's availability and/or resources. The most recent amendment of the Law of Protecting the Rights of the Elderly requires adult children to visit their elderly parents living alone in the community (Hatton, 2013), which reinforces the reliance on family to provide long-term care. However, it is crucial to recognize the ever-growing needs for a long-term care continuum in urban China (Hatton, 2013; Feng et al., 2012).

First, proactive and reactive decision-making dynamics can inform the establishment of home- or community-based service support programs. For example, several children in this study took precautions to institutionalize their parents, while their parents considered themselves still

independent. Home- or community-based long-term care may meet both generations' needs and avoid curtailing elders' remaining independence. As the newly amended Law of Protecting the Rights of the Elderly requires children's emotional support for elderly parents (Hatton, 2013), home- or community-based long-term care may be relatively more promising than nursing home care.

Second, tailored and specialized home- and community-based services may save more nursing home care resources for the group of elders most in need. One reason for establishing more home- and community-based services is the socially-rendered "invisible" dementia population in China. Nursing homes need to better allocate resources and to be better prepared. Thus, this research calls for more policy support for the development of home- and community-based services in urban China with the aims of 1) recognizing the pervasive, increasing long-term care needs, and 2) saving resources for dementia care that will surely deplete family caregiving resources in unique ways and rapidly relative to "regular" long-term care needs.

Third, this study recognizes the growing formal long-term care needs of the baby-boomer generation in urban China. Children's perspectives on family caregiving and nursing home care, and their expectations of their own long-term care can inform future policy development to cater to this upcoming "grey tsunami" in China. The findings in this study suggest that the Chinese baby boomer cohort may have less belief in filial piety and lower expectations for within family caregiving. Their preferences for formal long-term care emphasize less family reliance but more paid social support. Future research on long-term care policy should focus on the development of socially acceptable and specialized formal long-term care options, preferably non-profit, community-based social support services, to meet this cohort's undeniable enormous caregiving needs in the coming decades.

Study Limitations

Limitations in the study design. First, the retrospective analysis of the experiences of deciding to institutionalize between generations might yield other findings with another time frame and/or population.

Second, Husserl's descriptive phenomenological approach makes it difficult to examine participants' interpretations. Descriptive phenomenology requires the author to accept whatever participants say in the interviews, even though it is complex and sometimes ambiguous discourse (Maggs-Rapport, 2001). For example, sometimes participants kept silent after describing one incident during the decision-making process. The author could feel that they might have been angry, disappointed, and frustrated but she did not want to interrupt the silence or to disrupt participants' streams of feelings. However, without participants' confirmation, the author could not know their exact feelings and interpretations during these silent moments.

However, descriptive phenomenology and Heidegger's interpretive phenomenology are not mutually exclusive. Descriptive phenomenology seeks the essence of a phenomenon, while interpretive phenomenology reveals hidden meanings embedded in the participants' narrations (Maggs-Rapport, 2001). These interpretations would make sense when systematically supplementing the descriptions (Bevan, 2007). In this study, the author identified some of participants' interpretations along with their descriptions, for example, the discussion on reasons elders were against their children's proposal of institutionalization.

Limitations in the interview processes. Since elders and their children were interviewed retrospectively in this study, it is impossible for the author to analyze their *actual* conversation contents. The contents of intergenerational communication described were from a past time, as it existed in elders' and their children's memories, perceptions, and interpretations. Although this

characteristic of the data is ideal for phenomenological research, some inaccurate descriptions may have occurred due to participants' naturally diminished memories. Even so, what they remember probably has more meaningful and memorable.

Furthermore, although semi-structured in-depth interviews may be an effective way to collect qualitative information, some participants may have hidden their true feelings, while others may have tried overly hard to cooperate by offering the author responses that they perceived to be helpful. For example, elders may have overly emphasized how their children supported them unconditionally, while children may have deliberately omitted troubled aspects of intergenerational relationships.

Limitations in the sampling technique. First, a purposive sample may be biased. Participating elders were recruited from social workers' recommendations and/or through interest groups in the nursing home. It is possible that participating elders were comparatively more outgoing and more confident in discussing personal and social experiences with an outsider than those who were not recruited but also lived in the same nursing home. This sampling strategy may have resulted in a selection bias. Since the goal was generalization to theory and not to a population estimate, this is not a major concern.

Second, a purposive sample may draw a group of participants with overly similar demographical characteristics. Although this study did not seek generalization to a population of dyads, the sample intentionally consisted of more women than men to match the gender ratio in the nursing home. Indeed, this ratio may be due to the unbalanced longevity between genders. However, it could also be due to female elders being more open to nursing home care. Gender differences in perceiving nursing home care among elders need more investigation.

In addition, a purposive sample may be too limited. The sample in this study was limited to participants with similar income levels and within a particular geographic area. Future research with a larger and more diverse population may uncover a greater breadth of experiences of institutionalization. The scope of theory employed in this study would arguably minimize drastically different findings in any case.

Limitations in the researcher's stance. Conducting interviews requires the researcher to act as a research instrument and effectively guide the interview in a way that elicits subjects to open up about their experiences. However, as a form of data gathering, the interview is not a neutral tool. Instead, it is an interaction between the participant and the researcher, which is subject to various elements of the environment and context where the interview takes place (Rubin & Rubin, 2005; Fontana & Frey, 2003) as well as to the personality and background of the researcher (Moustakas, 1994). Two specific limitations of the researcher's stance need to be considered when interpreting the findings in this study.

First, this study is subject to the pitfalls of the lone analyst (Patton, 1999). The author maintained a reflexive and ethical commitment to data collection, kept a rigorous audit trail for data analysis, and discussed analyses and findings extensively with her adviser. However, data interpretation may not be value free (Pascal, 2010). The data analysis may be more or less biased from the author's own perspective; the author may have attended to some aspects of the data more astutely than others.

Second, this study is influenced by the author's previous study. The author conducted a similar study (Chen, 2011), interviewing only elders in a different nursing home. This experience may have imposed some difficulties in bracketing the author's own experiences and perspectives

on deciding to institutionalize. Indeed, it is impossible for researchers to completely bracket all personal experiences in a phenomenological study (van Manen, 1990).

Informing the Next Step

Decision-making dynamics. Future research on decision-making mechanisms around institutionalization can compare how adult children decide for their elderly parents and for childcare for their younger children. This study illustrates age dynamics in the decision to institutionalize between elderly parents and middle-aged adult children. Adult children emphasized the practicality of nursing home care in the face of overwhelming needs for instrumental assistance, whereas elderly parents valued emotional connections and the virtue of filial piety.

Such decision-making processes can be compared with parents' decisions to choose childcare for younger children. Existing research suggests that when choosing childcare, parents tend to focus more on the feasibility of childcare and their own priorities than on other factors (Kim & Fram, 2009; Peyton, Jacob, O'Brien, & Roy, 2001). Quality of service is another important factor to parents, such as the warmth of caregivers and curriculum design (Rose & Elicker, 2008). This choice is also related to social desirability, regardless of parents' constraints in making such a decision (Kim & Fram, 2009). However, the relationship with their younger children and maternal sensitivity may not seem as important to parents, and family needs may outweigh other values when they make the childcare decision (Peyton et al., 2001).

Thus, similarities exist in adults' making institutional decisions for their elderly parents and for younger children. They have to balance feasibility, social desirability, and caregiving

expectations, as their expectations may not always fit with what they are actually able to choose (Kim & Fram, 2009).

Utilizing long-term care. First, future research on the utilization of long-term care can add the healthcare providers into the decision-making process. As most children check the nursing home before finalizing the decision, their interactions with staff also have some effect on the decision-making. In particular, the children in this study expressed their concern about their parents' relationship with staff. As such, communication with service providers seems equally important to decision-making around institutionalization and the overall caregiving relationships.

Second, future research on the utilization of long-term care can draw on the specific caregiving needs and expectations identified in this study. Interviewing another 12 matched dyads of elders who live in the community and their primary child caregivers and comparing results with the findings in this study could bring different perspectives on long-term care. One could also design a large-sample survey study to assess community-dwelling elders' various long-term needs in urban China. As baby boomers approach retirement age, it is a critical time to clarify their needs and invest in more research on future long-term care design and classification. The current "catch-all" nursing home care in urban China can be tailored to better serve the growing aging population in order to support both the baby-boomer and the only-child generations.

Evolving intergenerational relationships. Future research on intergenerational relationships can situate intergenerational communication as the interpersonal interface and observe the longitudinal trajectories of both generations' conceptualization of filial piety. Discussing caregiving arrangements with each other, each generation could present their unique perspectives, which may have been influenced by their own generation's experiences. For

example, deciding to institutionalize becomes an ideal platform to explore different perspectives on family caregiving and nursing home care between generations. The divergent understandings of filial piety between generations are vital to current long-term care and its future development. Considering traditional cultural values and identity around caregiving is also essential to the development of Chinese long-term care policy (Holroyd, 2003).

Conclusion

This phenomenological study investigated the decision to institutionalize among nursing home elders and their children in Shanghai. Two generations (i.e., 12 matched dyads) were interviewed retrospectively about their experiences of family caregiving, intergenerational communication, and uncertainty management in this decision-making process. This study also explored the psychosocial contexts pertaining to this decision. This study developed a conceptual framework, integrating crisis theory, social identity theory, and uncertainty management theory to capture the fundamental phases of participants' deciding to institutionalize.

The essence of participants' experiences of deciding to institutionalize was that elders and their children proactively or reactively chose institutionalization in the face of depleting or depleted family caregiving resources. They experienced disrupted caregiving arrangements, family caregiving crises, and strained intergenerational relationships, which may have triggered the decision to institutionalize. While each generation, respectively, had its own motivation to institutionalize and protect their positive social identity; children exerted strong decision-making power. Children had strong preferences for nursing home care, if only because it provided professional healthcare, while for elders it was not easy to recognize the advantages of nursing home care and admit that family caregiving might be inadequate.

Both generations acknowledged the evolution of filial piety in contemporary Chinese society. Filial piety may have become less practical for children in the face of caregiving crises, but it remained morally meaningful to both generations. Elders began to accept the once-stigmatized institutional caregiving, even as they clung to nostalgia for filial piety, while their children had a growing detachment but sustained a vigilant awareness of its social desirability.

Based on these findings, this study encourages future research to examine decision-making dynamics around institutionalization within families across service providers' position in long-term care utilization, and throughout the longitudinal evolution of filial piety in urban China. This study informs policy to develop diverse and specialized home- and community-based long-term care in order to cater to various needs of the growing Chinese aging population. This study informs social work practice to establish specific needs assessment criteria, to improve communication in caregiving relationships with service providers, to advocate for elders' decision-making autonomy, and to develop detailed geriatric training for frontline social workers. These implications address the importance of catering to the needs for long-term care of Chinese baby boomers—the world's largest aging population in the coming decades.

APPENDIX A: Interview Guide–Nursing Home Residents

Thank you very much for participating in this interview. The main purpose of this interview is to gather information about the decision between you and your children for you to move into the nursing home.

Basic demographic questions:

Age, number of children, functioning health status, health history

Potential ice-breakers:

Please tell me the story of how you made the decision to move into the nursing home.

Interview questions:

Crisis theory

1. When did you begin thinking about moving into a nursing home?
 - Under what circumstances?
 - What was happening that started you thinking about this possibility?
 - Who else, besides yourself, was involved in making this decision?
 - What examples do you have in mind?

Intergenerational communication

2. Would you describe some conversations between you and your children about going to a nursing home?
 - In your memory, what conversations between you and your children made the greatest impression on you when you discussed the issue?
 - What did your children say?
 - What were your responses?
3. What were the major factors/motivations for you or your children in deciding to move into the nursing home?
 - What were your opinions about these factors/motivations?
 - What were your children's opinions about these factors/motivations?

Uncertainty management

4. What did nursing home care mean to you at that time? What did home care mean to you at that time?
 - How did you imagine life in a nursing home at that time?
5. What aspects of nursing home you considered uncertain when you made the decision? What about your children?
 - What aspects did you feel most uncertain about? Would you give me some examples?
6. How different are the services you are receiving in the nursing home now from what you anticipated before moving in?

7. How did you and your children reach the final decision to enter the nursing home?
 - Who made the final decision?
 - How did you think about it?

Filial piety

8. How would you describe the relationship with your children before and after moving into the nursing home?
 - How often do your children come to visit? Call you on the phone?
9. What did your relationship with your children mean to you before moving into the nursing home, and what does it mean to you now?

Speculation

10. If you were able to design the ideal alternative for living arrangements for elders other than living with your children, what would that be?

Interview Guide–Nursing Home Residents (Chinese)

非常感谢您参加这次的面谈。此次面谈对我这个关于代际交流在入住养老院过程中的影响的课题有很大的帮助。

基本问题:

年龄，子女数量，健康状况，健康历史

破冰问题:

请您和我谈谈你怎么做出入住养老院的决定的。

面谈问题:

危机理论

1. 您什么时候开始考虑要入住养老院的?

- 在什么样的情况下开始考虑的?
- 在您考虑入住养老院的可能性的时候，有什么事情发生么?
- 有哪些例子么?
- 除了您以外，还有谁也参与到做出入住养老院这个决定中呢?

代际沟通

2. 您能和我描述一些当您和您的子女在做出入住养老院的决定过程中，你们之间谈话的片段吗?

- 请您回忆一下，您印象最深的关于这个决定的谈话是什么?
- 您的子女说了点什么?
- 您的反应又是什么呢?

3. 您和您的子女做出入住养老院的决定有哪些主要的动机或者受到哪些因素的影响?

- 您是怎么看待这些动机和因素的?
- 您的子女是如何看待这些动机和因素的?

不确定性管理

4. 在您入住养老院之前，机构养老对您意味着什么？家庭养老对您意味着什么？

- 一开始您是怎么看待机构养老的?
- 一开始您是怎么想像机构养老的生活的?

5. 当您做出入住养老院决定的时候，您对于哪个方面是最不确定的？您的子女是如何看待这种不确定性的？

- 您最不确定的有哪些方面？有哪些例子么？

6. 您在入住之前和之后相比，您觉得机构养老的服务有哪些不同？
7. 您和您的子女是如果达成入住养老院这个决定的？
 - 谁做出最后的决定？
 - 您怎么看待这个决定？

孝道

8. 您怎么描述您和你子女的关系入住养老院之前和之后相比？
 - 多久您的子女来养老院探望您？或者打电话给您？
9. 您觉得入住养老院之前和之后相比，您和您子女之间的关系有何变化？

发散问题

10. 除了家庭养老之外，您理想中的养老方式是怎么样的？

APPENDIX B: Interview Guide–Child Caregivers

Thank you very much for participating in this interview. The main purpose of this interview is to gather information about the decision between you and your parent(s) for your parent(s) to move into the nursing home.

Basic demographic questions:

Age, number of children, type of work

Potential ice-breakers:

Please tell me the story of how you made the decision to let your parents move into the nursing home.

Interview questions:

Crisis theory

1. When did you begin thinking about your parent(s) might need to move into a nursing home?
 - Under what circumstances?
 - Would you give me some examples of what was happening that started you thinking about this possibility?
 - Who else, besides yourself, was involved in making this decision?

Intergenerational communication

2. Would you describe some conversations between you and your parent(s) about going to a nursing home?
 - In your memory, what conversations between you and your parents made the greatest impression on you when you discussed the issue?
 - What did your parents say?
 - What were your responses?
3. What were the major factors/motivations for you or your parents in deciding to move into the nursing home?
 - What were your opinions about these factors/motivations?
 - What were your parents' opinions about these factors/motivations?

Uncertainty management

4. What did nursing home care mean to you at that time? What did home care mean to you at that time?
 - How did you consider nursing homes in the first place?
 - How did you imagine your parents living in a nursing home at that time?
5. What aspects of the nursing home were you uncertain about when you made the decision? What about your parents?

- What aspects did you feel most uncertain about? Would you give me some examples?
6. How different are the services your parent(s) are receiving in the nursing home now from what you anticipated before they moved in?
 7. How did you and your parents reach the final decision to enter the nursing home?
 - Who made the final decision?
 - How did you think about it?

Filial piety

8. How would you describe the relationship with your parent(s) before and after your parent(s) moved into the nursing home?
 - How often do you come to visit? Call your parents on the phone?
9. What does intergenerational relationship mean to you before and after moving your parent(s) into the nursing home?

Speculation

10. If you were able to design the ideal alternative for living arrangements for elders other than living with you, what would that be?

Interview Guide—Child Caregivers (Chinese)

非常感谢您参加这次的面谈。此次面谈对我这个关于代际交流在入住养老院过程中的影响的课题有很大的帮助。

基本问题：

年龄，子女数量，工作

破冰问题：

请您和我谈谈你怎么做出入住养老院的决定的。

面谈问题：

危机理论

1. 您什么时候开始考虑您的父母要入住养老院的？
 - 在什么样的情况下开始考虑的？
 - 在您考虑您的父母入住养老院的可能性的时候，有什么事情发生么？
 - 有哪些例子么？
 - 除了您以外，还有谁也参与到做出入住养老院这个决定中呢？

代际沟通

2. 您能和我描述一些当您和您的父母在做出入住养老院的决定过程中，你们之间谈话的片段吗？
 - 请您回忆一下，您印象最深的关于这个决定的谈话是什么？
 - 您的父母说了点什么？
 - 您的反应又是什么呢？
3. 您和您的父母做出入住养老院的决定有哪些主要的动机或者受到哪些因素的影响？
 - 您是怎么看待这些动机和因素的？
 - 您的父母是如何看待这些动机和因素的？

不确定性管理

4. 在您父母入住养老院之前，机构养老对您意味着什么？家庭养老对您意味着什么？
 - 一开始您是怎么看待机构养老的？
 - 一开始您是怎么想像您的父母在机构养老生活的？
5. 当您的父母在做出入住养老院的决定的时候，您对于哪个方面是最不确定的？您的父母是如何看待这种不确定性的？
 - 您最不确定的有哪些方面？有哪些例子么？
6. 您的父母在入住之前和之后相比，您觉得机构养老的服务有哪些不同？

7. 您和您的父母是如果达成入住养老院这个决定的？

- 谁做出最后的决定？
- 您怎么看待这个决定？

孝道

8. 您怎么描述您和你父母的关系入住养老院之前和之后相比？

- 多久您去养老院探望您的父母？或者打电话给您的父母？

9. 您觉得您的父母入住养老院之前和之后相比，您和您父母之间的关系有何变化？

发散问题

10. 除了家庭养老之外，您理想中的养老方式是怎么样的？

APPENDIX C: Ethical Considerations

Ethical issues related to protection of the participants in the study are critical to the research process (Marshall & Rossman, 2006; Berg, 2004; Scharm, 2003). The author is responsible for informing and protecting these participating elders and their children who choose to participate in this study. As such, this study emphasized voluntary cooperation to inform participants about the study's purpose, treated information collected from participants with respect, and protected any identifying information. It is predicted that no serious ethical threats to participants will result from this study. However, at the same time, this study still took several precautions to protect participants, such as cultural considerations and risk/benefit analysis.

Cultural Considerations

This study included cultural groups in which there might be a reluctance to talk about personal experiences. The author confirmed that their experiences were for this study only. They will not be used for any other kinds of purposes. The author also confirmed that participants' refusal to participate in the study would not affect the care of elders under any circumstances.

Furthermore, keeping in mind of the social desirability of family caregiving, the author did not disclose the responses from each generation. In case of data contamination and interview reaction of the participants, the author maintained as neutral as possible during interviews.

Risk/Benefit Analysis

The author put the ethical considerations upfront to achieve more benefits for participants and have precautions to avoid any potential risks throughout the study procedures, despite some discomforts in the interviews. Participating elders recalled some unpleasant memories regarding

the negotiations with their children and their declined health conditions. Their children also underwent some stress when talking about their caregiving experiences.

The study itself may help to improve nursing home entry for elders. The author provided further information about Shanghai's current health care practice and long-term cares services at participants' request. Participants had access to more knowledge about additional resources and better understanding of services and health care system for the participant and family. Ultimately, the benefits of such a study outweighed potential risks to participants. When this study is complete, all interested participants will receive a summary of results if they desire.

Data Management and Data Safety

Due to the private or even stigmatized nature of deciding to institutionalize in participating elders' impression, there were specific plans for managing the identifiable private information of the participants. The author maintained privacy in the study setting by conducting interviews in a private room provided by the nursing home. The only identifying information collected about participants was their name and age. These identifiers will be removed from all transcripts, and replaced with identification numbers. Participants' personal identifying information was coded using letters and numbers to represent participating elders and their children. For example, E(ld)1...N sequentially represented participating elders and C(hild)1...N represented their children. The key to the identities of the respondents' identifiers was kept separately in a computer-password-protected file, and was only accessible by the author. The author finally gave pseudonyms for each participant for the purpose of writing cohesiveness.

Data were saved in both paper and electronic form. Personal information, audio recordings, and the master list were stored in the author's secured office at the University of California, Los Angeles (UCLA). Computer-based files were also used safely with caution. The

key to the code was in an encrypted and/or password protected file. The coded data file was maintained on a separate computer/server. After the study is completed, all data files will be stripped of personal identifiers and/or the key to the code will be destroyed. Audio recordings will be transcribed and then destroyed or modified to eliminate the possibility that study participants can be identified.

Digital versions of the master list of identifying information and all audio-recorded interviews were stored in a file secured with a password in the author's laptop computer, which was also secured with a password and stored in a secure office. After the study, the master list and digital audio documents will be stored in the author's secure office at UCLA.

APPENDIX D: Detailed Family Synopsis

Cao Family

Mr. Cao – He used to live with youngest daughter. He sold his old apartment after his wife passed away. He moved in with youngest daughter and gave some of his savings to her as payment for her caregiving. However, he did not want to rely on his daughter for everything. He heard of institutional caregiving from his old friends. He felt too lonely at home and he wanted to interact with other people. Mr. Cao proposed institutionalization.

Ms. Cao – Youngest daughter. Her father used to live with youngest son, the only boy in the family. However, their younger brother moved away due to financial troubles. Ms. Cao had to undertake family caregiving responsibilities, as she lived the closest to her father. She was exhausted with all the family issues: brother fled, troubled relationship between her father and her husband, and her daughter taking her college entrance exam. Ms. Cao had no choice but to send her father to a nursing home for extra support. Ms. Cao finalized the decision with her sisters to institutionalize their father.

Chen Family

Mrs. Chen – She used to live with eldest son. She moved into the nursing home with her paralyzed husband. The caregiving pressure was unbearable for her and eldest son's family. She was hospitalized and eldest son was unable to take care of his father. Her eldest son decided to institutionalize both of his parents together.

Mr. Chen – Eldest son. Mr. Chen was not able to provide sufficient and professional caregiving that his father needed when his mother was hospitalized for pneumonia. He suggested institutionalizing his parents. His mother agreed and helped to persuade her paralyzed husband.

Mr. Chen researched nursing homes with his younger brother. Mr. Chen finalized decision with all his siblings to institutionalize his parents.

Fan Family

Mrs. Fan – She used to live with youngest son. Youngest son took care of Mrs. Fan and his father-in-law. Despite her son's spacious apartment, Mrs. Fan felt too lonely, especially after her son's father-in-law passed away. She proposed institutionalization twice. However, she did not get along with her roommate and she only stayed for 1 month for the first time. Mrs. Fan proposed institutionalization again 1 year later because she was too lonely at home.

Mr. Fan – Youngest son. Mr. Fan was against his mother's decision to institutionalize both times, though he worried about leaving his mother alone at home during the day. However, as his father-in-law, who had cancer, also lived with him, Mr. Fan could not provide sufficient caregiving to his mother. He had to agree with his mother and helped her move into the nursing home for the first time. Mr. Fan was glad that his mother moved back home after the 1-month stay in the nursing home. After his father-in-law passed away, Mr. Fan was surprised that his mother decided to institutionalize again. But he noticed that his mother's health condition was unstable. He concluded that institutionalization was needed. So he agreed with his mother's decision. Mr. Fan informed his siblings about their mother's decision to institutionalize both times. He and his eldest brother finalized decision.

Huang Family

Mrs. Huang – She gave her old apartment to eldest grandson for his wedding. Then she moved in with her eldest son. However, this son was diagnosed with cancer. Eldest son decided

that the youngest brother should perform the sons' traditional caregiving duties by taking care of Mrs. Huang. She had heart problems and used to go to hospital frequently. Youngest son considered the family caregiving inadequate to meet his mother's needs. Also, Mrs. Huang did not get along with her youngest daughter-in-law. Mrs. Huang proposed to institutionalize, in order to reduce the family caregiving pressure for her youngest son.

Mr. Huang – Youngest son. Mr. Huang's eldest brother used to take care of their mother. However, his eldest brother was diagnosed with cancer. As one of the two sons, Mr. Huang had to step up to provide family caregiving to his mother. Mrs. Huang has had heart problems and used to go to hospital frequently, which was beyond the family's caregiving capacity. Mrs. Huang proposed to institutionalize and Mr. Huang agreed. Despite his eldest brother's strong objection, Mr. Huang finalized decision to institutionalize his mother.

Lin Family

Mrs. Lin – She used to live with eldest son. She fell and broke her hip. She had surgery and was bedbound for over 6 months. Eldest son and daughter took care of her at home. The caregiving pressure increased tremendously. The children hired more than 10 paid caregivers, but no one was satisfactory. Eldest son decided to institutionalize Mrs. Lin. He also searched for a qualified nursing home. Mrs. Lin realized that the demands of caring for her were beyond the family's caregiving abilities. She wanted to reduce the children's caregiving pressure. She agreed with children's decision to institutionalize.

Mr. Lin – Eldest son. Mrs. Lin fell and had a hip replacement, which was beyond the family's caregiving capacity. Mr. Lin undertook the caregiving decision-making by tradition, that is, the eldest son made family decisions. He hired paid caregivers before institutionalizing

his mother, but these paid caregivers were unsatisfactory and lacked the necessary healthcare skills. He decided to institutionalize his mother. He searched for nursing homes, taking fees, services, and geographical distance from his home into consideration. Mr. Lin finalized decision to institutionalize his mother.

Nie Family

Mrs. Nie – She used to live with eldest son. She gave her eldest grandson her own apartment when he was getting married. When he could not provide family caregiving, her eldest son asked his second younger sister to take care of their mother. Mrs. Nie moved in with her second daughter. However, she did not get along with her son-in-law, though her second daughter provided good care. Mrs. Nie did not want to disturb her daughter's life, and she felt sorry for the awkward situation between her son-in-law and herself. She proposed institutionalization, as she believed that she was healthy enough to be able to adjust life in the nursing home.

Ms. Nie – Second daughter. It was not her responsibility to take care of her mother, because she had two elder brothers. However, neither of her brothers was able to provide caregiving at that time. Eldest brother asked her to take care of their mother. Ms. Nie complied with her eldest brother's decision and took care of their mother. However, as her mother got older, Ms. Nie was concerned that her home was far from hospitals, which might cause problems if her mother had emergent situations. In addition, Ms. Nie had to take care of her grandson as well, which was prioritized over her mother. Ms. Nie accepted her mother's decision to institutionalize and helped to search for eligible nursing homes.

Shen Family

Mrs. Shen – She used to live with youngest son. She decided to institutionalize. She was familiar with the nursing home, because her husband had lived there before he passed away. Also, she was very fond of the collective life style. She wanted to interact with more people rather than staying at home alone.

Mr. Shen – Youngest son. Mr. Shen was against his mother's decision, because his father had just passed away. However, he also thought his mother would be happier living in the nursing home with more interpersonal connections with fellow residents. Mr. Shen agreed and respected his mother's decision.

Wang Family

Mr. Wang – He used to live with his youngest daughter. He had a minor stroke and was hospitalized. He was barely recovered when his youngest daughter had a car accident. She could not continue to take care of him, so he suggested institutionalization.

Ms. Wang – Youngest daughter. Ms. Wang had a car accident after her father was recovering from a minor stroke. Ms. Wang realized that she could not continue to provide family caregiving for her father. However, her siblings did not undertake any caregiving or participate in the caregiving decision-making. She made the final decision with her father.

Yang Family

Mrs. Yang – She used to live with her second son, who considered it unsafe to leave her alone at home during the day. She also did not get along well with her daughter-in-law, who was

her primary caregiver. She found co-residence difficult. All her children came to the consensus to institutionalize their mother.

Mr. Yang – Eldest son. Although Mr. Yang was the second child, he was actually the eldest son. His wife was the primary caregiver at home. Mr. Yang worried about leaving his mother alone at home during the day. He discussed the situation with his siblings. He searched for nursing homes for his mother. Mr. Yang finalized decision to institutionalize his mother.

Ye Family

Mrs. Ye – She used to live with eldest daughter. She sprained and broke her ankle, and was hospitalized. Her eldest daughter took care of her in the hospital. However, her granddaughter gave birth to her great-granddaughter soon after she was discharged from hospital. Eldest daughter prioritized her own daughter over Mrs. Ye. The caregiving pressure after Mrs. Ye's surgery and the newborn baby became tremendous. Eldest daughter suggested institutionalization. Mrs. Ye had to agree, since eldest daughter had taken her apartment and she had nowhere to live by herself. Mrs. Ye first moved to a private nursing home, which did not provide proper services. Her daughter found the current nursing home, which provided for better services and was located closer to her home.

Ms. Ye – Eldest daughter. Intergenerational communication problems had existed for a long time in this family. Ms. Ye's health condition was deteriorating, which prevented her from providing adequate family caregiving to her mother. Her siblings did not participate in family caregiving for their mother at all. Meanwhile, Ms. Ye had a newborn granddaughter. She prioritized her granddaughter over her mother. Ms. Ye finalized decision to institutionalize her

Zhang Family

Mrs. Zhang – She used to live with youngest son. She did not get along well with her daughter-in-law. She reluctantly accepted her youngest son's decision to institutionalize, though Mrs. Zhang believed it was her daughter-in-law's idea. Mrs. Zhang first moved into a private nursing home, which was not satisfactory. Youngest son helped her move to the current nursing home.

Mr. Zhang – Youngest son. Mr. Zhang's wife was the primary caregiver at home. As the only son at home, Mr. Zhang had to provide caregiving and make caregiving decision for his mother. However, he did not have the necessary healthcare skills, as his mother's diabetes was out of control. He suggested institutionalizing his mother. He first found a private nursing home for his mother, who was not satisfied with the services. Then he found the current government-sponsored nursing home. Mr. Zhang finalized decision to institutionalize his mother alone, without consulting his sisters.

Zhou Family

Mr. Zhou – He used to live with his second daughter before his wife passed away. He had severe asthma. He gave his old apartment to his youngest son. His daughter felt this was unfair as she had taken care of their mother for a long time; she thought Mr. Zhou should have given the apartment to her instead of her brother. She did not want to take care of him anymore. He moved to his youngest son's place. However, the apartment was on the fifth floor, and the stairs were difficult for him to climb everyday. His health condition was not stable at that time and he had to go to the hospital almost every month. Youngest son worried about Mr. Zhou's condition and suggested that Mr. Zhou try institutionalization for the first moth. Hearing recommendations

of nursing home care from his friends, Mr. Zhou realized that a nursing home could provide professional healthcare to him, and he agreed with institutionalization.

Mr. Zhou – Youngest son. Mr. Zhou took his parents' apartment, which meant he had to provide family caregiving for his father. He was the only son, who was responsible for making the caregiving decision as well. His father's asthma was becoming worse, which was beyond the family's caregiving capacity. Mr. Zhou suggested institutionalizing his father. Mr. Zhou searched for nursing homes and finalized decision to institutionalize with his father.

APPENDIX E: Codebook

Research Question: How did nursing home residents and their adult children in Shanghai decide to institutionalize?

| Super Families | Major Families | Categories | Codes |
|-------------------------------------|---|---|--|
| Etiology of Caregiving | The unexpected reality of caregiving: “It’s like I was an intruder.” | Coresidence | Elders lived with children |
| | | | Elders moved among children’s homes |
| | | Trading property for caregiving | Trading housing for family caregiving |
| | | | Housing caused siblings not to provide family caregiving |
| | | | Elders lost sense of belongings |
| | | The caregiving gender paradox | Son’s privileges and responsibilities |
| | Sons made decisions for the whole family | | |
| | Sons had to undertake family caregiving responsibility | | |
| | Siblings deferred caregiving responsibility to brothers | | |
| | Familial discordance regarding caregiving tradition: “It’s not the same now.” | Good intergenerational relationships | Children showed a great deal of filial piety |
| | | | Close relationship with children |
| | | Strained intergenerational relationships | Elders did not get along well with children and/or children-in-law |
| Difficult communication with elders | | | |
| Two Players in One Game | Seizing remaining decision-making autonomy | Different living habits between generations | Different living habits from children |
| | | | Difficult to change living habits |
| | | Difficult living conditions | Elders felt lonely at home |
| | | | Inconvenience of children’s apartment |
| | | A proactive decision to meet psychosocial needs | Limited space in children’s apartment |
| | | | Elders’ desire to increase social interactions |
| | | | Elders’ desire to avoid strained intergenerational relationships |
| | | | Children had mixed feelings |

| | | | | |
|--|---|--|--|--|
| | | | Children agreed because they respected their parents' decision | |
| Preempting caregiving depletion | Elders' personalities changed | | Hard to communicate with parents | |
| | | | Elders became stubborn | |
| | Children's other caregiving priorities | | Children had own family to care for | |
| | | | Children had to take care of frail in-law | |
| | Hard to balance work and caregiving | | Children took early retirement | |
| | | | Children couldn't take care of both generations | |
| | Children's health problems | | Daughter had a car accident | |
| | | | Eldest son was ill | |
| | A proactive decision to meet instrumental needs | | Spouse was paralyzed | |
| | | | Daughter had a car accident | |
| | | | Whole family made the decision | |
| | | | Children took precautions | |
| | | | Elders rejected the decision at first | |
| | | | Elders took time to consider institutionalization | |
| | | | Elders felt obliged | |
| | The last straw: "We had no choice. They had no choice." | Elders' declining health condition before institutionalization | | Elders had accidents |
| | | | | Declining health status |
| | | Family caregiving could not continue | | Family exhausted from caregiving resources |
| | | | Inadequate family caregiving | |
| A reactive decision to meet instrumental needs | | | Too much caregiving pressure for children | |
| | | | Children sought professional healthcare for their parents | |
| | | | Children told parents to institutionalize | |
| | | | Elders wanted to reduce children's caregiving pressure | |
| Au Revoir Family Caregiving | Different uncertainties between generations | | Sharing a room | |
| | | | Stigmatized impressions of nursing home care | |

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| | | | Children asked their parents to try institutionalization |
| | | Mystery disentangled | Children searched for nursing homes |
| | | | Children checked out service quality |
| | | | Elders checked out the nursing home before moving in |

APPENDIX F: Significant Statements and Related Formulated Meaning

| Significant Statements | Related Formulated Meaning |
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| My father was living alone for a while after my mother passed away. I came to see him more often, almost every day, as we lived nearby. I cooked for him, shopped for him, and took him for a walk, things like that. But his health was not stable at that time, so I insisted on him living with me several months later. | Children worried about elders living alone and asked them to move in with them. |
| I was no longer able to live with my sons. They asked me to move in with my daughter, because their younger sister, who lives in this district, owns a spacious apartment. To be honest, I had nowhere to go at that point. I was like a ball bounced among them. No one wanted me. | Elders were powerless over being bounced among children. They felt abandoned. Children were condescending about their parents' living arrangements. |
| If my sons' apartments had been large enough, I would not have lived with my daughter, I would not have had to leave my old neighborhood, and I would not have had to move into this nursing home... It's all about housing. | Elders still had hopes of living with sons and not leaving familiar environment. Caregiving problems related to housing issues. |
| After my wife died, my daughter thought that she had contributed so much to taking care of her mother, and she deserved the apartment. However, now her younger brother had the apartment. She felt this was unfair. She did not want to take care of me any more. It was time for me to leave... I was like... I didn't expect that at all. I thought she would also take care of me until I passed away. | Elders hoped to be taken care of at home. They did not expect to be bounced among children. They were aware of children's understanding that housing could be exchanged for caregiving. |
| However, my nephew was getting married, and he took the apartment. My mother, um... had basically nowhere to go... My eldest brother asked me to step up to take care of our mother. | Frictions among siblings existed, due to unfair caregiving arrangements, especially when the child who was taking care of the parent did not receive the "payment" as he or she expected. |
| I thought they had already contributed too much for my husband. I did not want them to spend anything looking after me. I just did not want to trouble them. I thought they had already been troubled too much. | Elders did not want to trouble their children too much. |
| My daughter was too cautious about me when I lived with her. I knew that she had too much pressure to take care of my wife, and then, | Elders realized caregiving should be mutual. They did not want to be a burden on their children. |

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| <p>me... She devoted too much to us. I did not want to bother her. As my health condition permits, I would like to help her as well.</p> | |
| <p>You know, we Chinese elders, especially like me, an almost disabled old lady, want to rely on our children, not paid caregivers, not nursing homes; it's our tradition, isn't it? If everything was fine, like my eyesight was fine, my leg wasn't injured, I would like to stay at home and my children could take care of me, which would not be too much for them to do.</p> | <p>Elders would have wanted to stay at home with their children if they had not had too many health problems. They still preferred family caregiving, reminiscing about the Chinese caregiving tradition.</p> |
| <p>The government compensated us for two apartments. My husband and I decided to give our sons the two apartments and they agreed that in turn, they would take care of us until we pass away.</p> | <p>Elders used housing to trade for children's caregiving.</p> |
| <p>It was like [my eldest brother's family] dumped my mother on me. My mother, um... had basically nowhere to go. I had no choice. I am her son. Who else can she depend on? I have to step up...</p> | <p>Being a son sometimes meant more caregiving responsibilities, especially when siblings could not or did not want to take care of the parent.</p> |
| <p>Because my father sold his apartment and moved in with me, my brother thought I took all my father's money. He thought in that case he was done with my father. I have the full responsibility now...</p> | <p>Siblings refused to take on caregiving responsibilities because they were not compensated.</p> |
| <p>Although living with my son's family was OK... I still did not feel like it was home. I wanted to have some place that could give me the sense of belonging.</p> | <p>Elders lost a sense of belonging as they gave their own apartment to their grandchildren.</p> |
| <p>Because I lived with my son, I wanted to help them with housework, you know, I did not want them to take care of me for nothing. I tried to pay for my living expenses but my son refused to take any of my money.</p> | <p>Elders wanted to pay for their children's caregiving and expenses by doing housework or giving them money.</p> |
| <p>My daughter accompanied me to all the appointments. She also took me to see another traditional Chinese medicine specialist. She went to all kinds of troubles.</p> | <p>Elders appreciated their children's caregiving.</p> |
| <p>Daughters are more careful and considerate in caregiving. My daughter had taken good care of my wife. I trusted her for family caregiving.</p> | <p>Elders liked daughters' caregiving more than sons'.</p> |
| <p>I told my brother that I could not continue to take care of our mother... I asked if he could offer some help.</p> | <p>Children asked siblings for help taking care of elders.</p> |

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| I had to take the caregiving responsibility. | The feelings of responsibility and necessity were greater than the feeling of complying with filial piety. |
| Caregiving is mutual, you know, my mother should understand this. I was not asking too much, I think... | Children expected to be respected from their parents. |
| My three daughters do not make decisions, you know. Since their father passed away, my son makes decisions on all the family issues. Of course, my daughters come to see me very often and bring me food. But they do not get involved with important issues. | Elders considered the support their daughters provided only instrumental; daughters had limited decision-making capacity. |
| He called his sister and told her about his plan. My daughter didn't say anything because my eldest son made all the decisions for the whole family. | Children had to take care of elders, as they could not object to their eldest brother's decision. However, this was likely to affect their parents' caregiving arrangements. |
| After my father passed away, I was the one who made decisions for my family, though I am the second child, but I am the eldest son. I have to perform the duties of an eldest son—taking care of parents. | Being eldest sons meant that they could not avoid their duties of providing caregiving to their parents, which was governed by filial piety. |
| I am one of our mother's only two boys. I had no choice. I had to take care of my mother. | Children stepped up to take care of their parents because they were the sons. |
| My daughters do not take the responsibilities of caregiving, as my husband left me with my son, not them. They care about me, but they do not care so much... | Daughters did not have much decision-making power in terms of their parents' caregiving arrangements. |
| I have found that elders can be really hard to communicate with sometimes. I wanted to communicate with my mother, but it was so hard. She just didn't understand that I was not her servant. I don't have to work for her all the time. | Children believed that their parents thought they were servants. |
| As my father's health status was declining, his temper became eccentric. He got cranky really easily. | Elders became hard to take care of because their children did not know how to communicate with them. |
| So, my daughter told me that she couldn't take care of me any more. She couldn't manage so many things at the same time. It was too much for her. | Children had difficulties providing adequate family caregiving for their parents because they could not manage competing responsibilities at the same time. |
| I was sorry for my mother. I was unable to take care of both her and my grandson at the same time. My grandson is so little that I have to pay more attention to him than to my mother, as long as my mother's health is stable. | Children admitted that they did not prioritize taking care of their parents. |

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| <p>I knew that I could not ask for more caregiving because my in-law was not well. He had cancer and I was pretty healthy. It was not possible for my son and daughter-in-law to prioritize me.</p> | <p>Elders in relatively good health were a lower priority for their children's family caregiving than other family members with poorer health.</p> |
| <p>I didn't have extra strength to take care of my parents, especially when parents fell ill. I had to raise my son as well. The caregiving for both generations was unbearable for me.</p> | <p>Demanding caregiving responsibilities impeded children from performing family caregiving well.</p> |
| <p>I didn't think I was able to handle both work and caregiving very well.</p> | <p>Children admitted that they could not balance work and caregiving.</p> |
| <p>My eldest son was diagnosed with cancer. Thank goodness, it was at an early stage. But he still had surgery and went through chemo. But, as he was sick, there was no one to take care of me.</p> | <p>Elders were abandoned due to their children's illness.</p> |
| <p>But he did all kinds of housework at home. Before my institutionalization, sometimes I had to stay at hospital for a month every three months due to my heart problems. It was too much for my youngest son. He was not well and he had to take care of me. I worried about him.</p> | <p>Elders worried about their children's health status.</p> |
| <p>Because my mother has diabetes and she needs insulin shots at every meal, it became more and more difficult to provide the care that she needed and to monitor her blood sugar level.</p> | <p>Children could not manage their parents' deteriorating health conditions.</p> |
| <p>I like soft food as my teeth do not work that properly now, but I cannot ask my daughter-in-law to cook some soft food for me in particular. This wastes time and money.</p> | <p>Elders did not want to bother children-in-law.</p> |
| <p>It took me a long time to adjust to living with my son's family. We had very different living habits. My daughter-in-law is very very neat and clean.</p> | <p>It was hard for elders to adjust to life with their children's family.</p> |
| <p>I felt lonely at home. I used to stay at home all day and did not talk at all. My son and daughter-in-law go to work and grandson goes to school. I did not talk to in-law very much. I got bored staying at home.</p> | <p>Elders were lonely at home.</p> |
| <p>It was too much for my eldest son and my daughter. They had their own life, and I was bed-bound for too long. We were all exhausted. We couldn't afford any more troubles.</p> | <p>Elders worried about their children because of increasing caregiving pressure.</p> |

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| <p>When I was admitted to the hospital, both my physical and mental strengths were drained. I knew I was not able to take care of my husband any more. My health did not permit me to continue. I also realized that my children, especially my eldest son and his wife, were not able to continue.</p> | <p>Elders worried about their children's family and their ability to take care of them.</p> |
| <p>My son and daughter-in-law supported us 100%. But they had to work during the day. It turned out that I was the only one to take care of my husband during the day.</p> | <p>Elders realized that their children were not able to provide sufficient caregiving.</p> |
| <p>It is not safe for her to stay with me any more. After all, she is getting older and older. You don't know what is going to happen to her at any time.</p> | <p>Children worried about what might happen to their parents if they continued to live with them and about how this might result in a greater caregiving burden.</p> |
| <p>The private nursing home was more like a temporary transition for my mother. They do not have standardized service protocols. To be honest, I was quite worried about my mother when she was in the first nursing home. The food was not good. I had to bring dishes to her every two or three days. The private nursing home did not provide a special diet for residents with diabetes.</p> | <p>Private nursing homes provided low levels of services.</p> |
| <p>My sister checked several private nursing homes. They cost too much, though their buildings and equipment are quite new. We couldn't afford those private ones because we have to pay out of pocket for the fees in a private nursing home.</p> | <p>Private nursing homes charged higher fees.</p> |
| <p>In particular, the good healthcare services in the nursing home attract us. It was a huge plus. We were really worried about my father's health condition. We were not professional caregivers.</p> | <p>Children were attracted to institutionalization for its healthcare.</p> |
| <p>First, we did not have any healthcare skills. My mother picked up some when she watched how nurses took care of my father in the hospital. But those were far too little. It was beyond our abilities. Second, we did not think paid caregivers could have those skills either. So, we did not even think about hiring a paid caregiver. Then... it only left the nursing home.</p> | <p>Children struggled with not having any other caregiving choices. They compared all the alternatives that they could think of.</p> |
| <p>Living in a nursing home is much better than hiring a paid caregiver. Children can depend</p> | <p>Children wanted the assurance that their parents were being well taken care of by a</p> |

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| on nursing homes. At least there are doctors in the nursing home who can provide professional healthcare. | nursing home, rather than by less reliable paid caregivers. |
| I thought nursing home care couldn't compete with family caregiving. I don't think the staff can provide emotional support like families can. We Chinese like family caregiving no matter what. It's our tradition after all. | Children still believed in family caregiving, especially the emotional connection aspect, though they also turned to nursing home care for help. |
| If the elder is not so well, like my father, it is better to have him institutionalized. Children have to depend on nursing homes. At least there is a doctor to take care of my father 24/7. | If parents were not well, their children would definitely consider nursing home care. |
| It was really difficult for my father to live alone. I wanted him to move into a nursing home. So he could relax and have some fun with other elders. | Children considered how the nursing home could meet their parents' needs for social interaction. |
| I cannot picture myself at such a place with all other elders. What I had imagined for old age was to be taken care of by my children and passed away in a hospital... Just like my husband. | Elders had no idea about nursing home care. |
| He had a very old impression of the nursing home as a place for childless elders and the mentally ill. He did not want to stay with other elders. He said, "They would reduce my spirit." | Elders had old and stigmatized impressions of nursing homes. |
| Many of my old colleagues were living in nursing homes. They were satisfied with their life in the nursing home. I was able to visit them from time to time back then. I saw the environment and services. So an idea occurred to me that I should also move into a nursing home. | Elders considered institutionalization based on friends' experiences. |
| Some of my friends lived in other nursing homes. They told me that I could get good caregiving in the nursing homes and I did not need to rely on children. | Elders did not want to depend on their children, so they chose institutionalization. |
| I talked to my mother: "If you want me to live longer, you have to obey what I said and move to the nursing home. It will benefit both of us. Otherwise, we will keep fighting with each other at home. Then, I may have a heart attack and pass away before you, just like my father." | Children told their parents they could not take care of them any more. |
| "But you are getting older and older. God forbid, if anything happens to you when you | Children spent time trying to persuade their parents to institutionalize. |

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| <p>are alone at home, we cannot handle the situation. A nursing home offers more sophisticated healthcare for elders. They are better than us. We still love you. We look for what's the best for you. We will still come to see you every week." I had talked to her for weeks...</p> | |
| <p>I talked with my father about the situation. I told him that I worried about him. I told him that I was not able to take good care of him. If he moved to a nursing home, he could be taken care of... At least he would have three meals a day and healthcare services.</p> | <p>Children listed reasons for institutionalizing their parents; they considered themselves unable to continue to provide adequate family caregiving and sought nursing home care for extra help.</p> |
| <p>She is now pretty healthy. But I don't know how she is going to be in years to come. I would like her to institutionalize and adjust to the life [there] in advance. If she becomes really ill, and cannot take care of herself any more, it would be more difficult for her to move into a nursing home.</p> | <p>Children wanted their parents to adjust to institutional life in advance.</p> |
| <p>I asked about his opinion first. I asked something like, "Dad, what do you think of nursing homes?" He was like... um... "Fine... What about it?"</p> | <p>Children probed their parents' attitudes toward institutionalization first.</p> |
| <p>I told him if it was possible for him to try it for one month to see if he liked the nursing home. I told him that he's not well and he needs professional healthcare. I know my father can be difficult to live with, which may cause problems with sharing a room. So, I asked him to try one month.</p> | <p>Children were uncertain about institutionalizing their parents, so they suggested it as a temporary solution.</p> |
| <p>We listed our difficulties taking care of her and told her about our worries. I told her, "This is a temporary decision. If you do not like the nursing home, we will definitely take you back home."</p> | <p>Children tried to persuade their parents to institutionalize by assuring them of the continuous availability of family caregiving.</p> |
| <p>I told my son that I wanted to move into a nursing home for the first time about three years ago. He agreed. He said, "OK. I will find you one. If you do not feel like living there any more, you can always go back home." The second time was after my in-law passed away. I officially had no one to talk to. So, I asked my son to take me here again. He agreed.</p> | <p>Elders asked to institutionalize because they were too lonely at home.</p> |
| <p>I proposed the idea of living in a nursing</p> | <p>Elders wanted to stay independent from their</p> |

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| <p>home. I told my youngest son and his wife that I wanted to come here. They came here to check it out. They did not believe that I was really going to move at first. But I insisted on coming here. I heard that this nursing home is one of the best in the whole city. I had to seek a way for myself.</p> | <p>children.</p> |
| <p>I was not worried or concerned. This nursing home is the best I could find... Its service is excellent. It is government-sponsored, so it can be trusted. The staff here is really good and kind to residents. It is close to my place. It's very convenient for me to come by often.</p> | <p>Children did not have uncertainties about institutionalizing their parents.</p> |
| <p>I checked out all the nursing homes nearby. This one is government sponsored at the municipal level, which is really dependable. So I trusted the services and staff here.</p> | <p>Children trusted government-sponsored nursing homes.</p> |
| <p>I worried about my mother. I was not sure if she was able to adapt to life in the nursing home, you know, the new lifestyle, like sharing a room with the other resident. It's a brand new living environment for her.</p> | <p>Children were concerned about their parents' adjustment to life in a nursing home.</p> |
| <p>Staff is different. They are not family. Residents have to depend on them to have the essential services in the nursing home. I was worried about my mother would not be getting along with them. I was not sure if they would mistreat my mother.</p> | <p>Children were concerned about their parents' relationships with staff in the nursing home.</p> |
| <p>The most uncertain... you know, it is not like living at home any more. It's gonna be difficult. Living conditions will be totally different, and you have to share the room.</p> | <p>Changes in living conditions were distressing for elders.</p> |
| <p>I only heard from my son that there were doctors in the nursing home who could provide healthcare and prescribe medication. I thought that was sufficient. I didn't think too much about my institutionalization. It's just life. I accept whatever life brings me.</p> | <p>Elders passively accepted their children's decision to institutionalize.</p> |
| <p>The only requirement from my father is the hygiene of the nursing home. He said, "Find me a clean nursing home and a clean room." I said, "I know. I know. I know what you want. I will take care of it."</p> | <p>Elders had specific requirements for a nursing home and their children understood.</p> |
| <p>My mother doesn't want to leave this neighborhood. She spent almost her whole life living in this area. So I only focused on</p> | <p>Elders did not want to leave familiar neighborhoods.</p> |

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| nursing homes in this district. | |
| He asked me to come to see him as often as possible. I agreed. I understood that my father needed a slow process to adapt to the new life in the nursing home. I selected this nursing home that is close to my home. So I can visit as much as possible. | Elders asked their children to visit as much as possible, indicating their strong attachment to their children. |
| We kept my father's requirements of close distance and hygiene in mind and narrowed down to two nursing homes. One was this one, and the other was comparatively farther away. So we decided on this one. | Children wanted a nursing home close to their home. |
| I came here and checked the room, the service, the food and the healthcare in this nursing home for several times before deciding to send my mother here. | Children paid special attention to service quality of the nursing home. |
| My brother and I came here once to check it out. The staff here was really nice. They showed us the kitchen, the room, the activity place, and the garden. Both of us liked this place. | Siblings helped search for a qualified nursing home. |
| My daughter and son-in-law brought me here. I remember my first impression was clean. This place was very clean. I saw several staff members and watched how they took care of residents. I even tried the lunch that time. We were all satisfied with it. | Children made sure that their parents liked the nursing home by bringing them to examine the services before moving in. |
| I talked with my siblings about the idea of sending our mother to a nursing home. My sister and brother agreed immediately because we all thought professional healthcare would benefit our mother. They wanted to solve the caregiving problem and provide better care for our mother. | All siblings agreed to institutionalize their parents. |
| I gathered my siblings together to discuss this decision several times. First, we discussed the possibilities of sending my mother to a nursing home. They agreed with me about the professional healthcare in the nursing home, and the possibilities of my mother's falling at night. | Children had family meetings to reach consensus to institutionalize their parents. |
| My mother made the decision too, yes, yes, she was totally mentally competent and physically capable at that time, she was definitely involved in the decision, we didn't, um, didn't decide for her, we helped her to | Children did not decide for their parents. |

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| decide. We didn't say, "Mom, you have to move in a nursing home" right away. She was aware of what we were doing the whole time. | |
| My father finally noticed his strength was diminishing after the stroke. He had been staying in bed for a long time. He finally realized that he was not young any more... He gradually understood why we proposed to institutionalize him. Then he agreed to institutionalize. | Elders realized that their declining health conditions had become a burden for their children, which prompted them to accept their children's decision to institutionalize. |
| [It was] my eldest brother. My dad passed away, so my eldest brother has become the one who makes all the important decisions for the whole family. Although he was not involved as much as I was, I still needed his permission to send our mother to the nursing home. | Sons made the decision to institutionalize their parents. |
| It was me who made the final decision. After all, I was the one who took the most responsibility of caregiving. My father relied on my decision. | Daughters decided on caregiving arrangements for their parents when they were the primary caregivers. |
| My son did not say much about sending me to the nursing home. It was his wife's idea. My son follows whatever she says... | Elders were powerless in the decision-making process. |
| When my son told me that he was considering sending me to a nursing home, I immediately thought about abandonment. I was devastated... It really upset me. I did not sleep well for weeks. | The decision upset elders. |
| My mother was quite against this decision at first. She didn't understand why we wanted to send her to a nursing home. She just thought we wanted to abandon her. She said that she would live alone rather than live in a nursing home. | Elders were against the decision. |
| I thought it over for about a week. I was nervous about leaving everything that I was familiar with and moving into a new environment. I did not know what to expect. | Elders were nervous about the decision to institutionalize. |
| My father declined firmly. He did not want to live with other elders. He said, "I'm already old enough, I don't want to have more elders in my life." | Elders rejected the decision at first. |
| [My daughter] had no choice. I had no choice. I pitied my daughter and son-in-law. They did too much for me. I was too weak to do | Elders wanted to reduce their children's caregiving pressure. |

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| anything at that time. I wanted to reduce my daughter's pressure... I agreed to move into this nursing home. | |
| I lived with my daughter for all my life. It was my turn to consider her life, I guess. I hesitated about moving to a new place, you know, I am too old to move. But my daughter was quite determined to have me moved. | Elders agreed to institutionalize for their children's sake. |
| My son told me that he had done some research and pulled some connections to find me a bed in this nursing home. Hearing that, I knew I could not blow it off. He had spent so much effort for me to find a place. So I had to accept this decision. I just made up my mind to come here. | Elders did not want to let their children down. |
| Gradually, I persuaded myself to accept the decision. I have been determined to be independent ever since. | Elders managed to accept their children's decision to institutionalize. This decision influenced their desire for maintaining freedom and independence during later life. |
| My daughter didn't say anything. She was in such a pickle between husband and mother. How could she have any opinions? My sons didn't even care. | Children did not care about their parents' decision to institutionalize. |
| [My son] was so surprised. He did not expect that at all. He was strongly against it. He said that his father had just passed away, and he insisted that I should stay with them. | Children were against their parents' decision to institutionalize. |
| I am her son. I had to respect her decision as a way to show my persistence of filial piety. I had to agree with her decision. | Children had to agree with their parents, due to filial obligations. |
| My eldest son was furious. He said, "Our mother is not childless. She has 5 children. How can she go to a nursing home?" But at that time, he was going through chemo. He didn't have extra strength to take care of me, so he had to agree. My daughters were not against my decision. They thought nursing homes could be worth trying. They knew that I was unhappy living with their younger brother. | Children had mixed feelings about institutionalizing their parents. |
| They were quite surprised at my decision at first. However, they knew that I could be stubborn, haha, so they did not even try to argue with me. They agreed with me. | Children agreed with their parents' decision to institutionalize without arguing with them. |
| I have been very close with my son. We share strong emotional closeness with each other. | Elders shared close relationships with their children. |

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| <p>My son carried me downstairs every time my asthma broke out at night. Sometimes he called an ambulance, and sometimes he drove himself. He devoted a lot to taking care of me. I consider that he has performed excellent filial piety to me.</p> | <p>Elders were pleased with their children's expressions of filial piety.</p> |
| <p>My father thought my sister wanted to abandon him; you know, elders are very sensitive to children's attitudes. My father was kind of depressed. He was not happy.</p> | <p>Children's attitudes toward caregiving (if they were willing to perform filial piety) directly influenced elders' feelings about family caregiving.</p> |
| <p>Daughters are families. Daughters-in-law are not families after all.</p> | <p>Elders did not get along well with children-in-law.</p> |
| <p>We had troubles in communication for a long time, which annoyed me very much.</p> | <p>Children had difficulties communicating with their parents.</p> |

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