

EXPERIENCE OF CAREGIVING DAUGHTERS-IN-LAW  
IN SOUTH KOREA

by

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(Under the direction of DR. MARGARET ROBINSON)

ABSTRACT

The purpose of the study is to define the caregiving stress process of Korean daughters-in-law who provide care for their parents-in-law in the same household and to investigate to what extent filial obligation is related to the variables in the caregiving stress process. A survey using a structured questionnaire was conducted to address the research questions. Participants were 152 caregiving daughters-in-law who live with their parents-in-law in the same household in Korea.

The findings of the study revealed that filial obligation was an important component which helped to explain the variation of caregiving satisfaction and caregiving burden in the caregiving process model. However, filial obligation did not impact on the explaining the variance of caregiving outcomes, which were life satisfaction and depression. Caregiving daughters-in-law with higher levels of filial obligation seemed to experience higher levels of caregiving satisfaction and life satisfaction regardless of the levels of social support, while they were likely to experience lower levels of caregiving burden when the effect of social support was controlled.

Positive relationships were exhibited between caregiving burden and depression, and between caregiving satisfaction and life satisfaction when controlling for the levels of social support. A negative relationship was revealed between caregiving burden and life satisfaction regardless the levels of social support. Additionally, social support showed stronger relationships with caregiving burden and depression than with caregiving satisfaction and life satisfaction, however, the findings indicated that social support had little impact on the caregiving process. In conclusion, this study attempted to test the caregiving process model developed in the Western culture within the context of Korean culture, and provided a useful conceptual framework and information for better understanding of Korean family caregiving practices.

INDEX WORDS: Caregiving, Daughters-in-law, Parents-in-law, The Elderly, Filial Obligation, Caregiving Tasks, Caregiving Satisfaction, Caregiving Burden, Social Support, Life Satisfaction, Depression

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## TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS .....	iv
LIST OF TABLES .....	ix
LIST OF FIGURES .....	xi
CHAPTER	
1 INTRODUCTION.....	1
Conceptual Framework.....	1
Background.....	3
Statement of Problem.....	5
Purpose of the Study .....	6
Significance of the Study .....	7
2 LITERATURE REVIEW .....	10
Nature of Caregiving in the U.S. ....	11
Nature of Caregiving in Korea.....	12
Caregiving with Cultural Norms.....	13
The Change in Cultural Norms on Caregiving in Korea .....	19
Caregiving Experiences .....	23
Summary .....	30
3 CONCEPTUAL FRAMEWORK.....	31
Background and Context of Stress.....	32



	Sources of Stress .....	33
	Moderators .....	36
	Stress Outcomes .....	38
	Research Model .....	38
4	METHOD .....	41
	Research Design.....	41
	Sampling and Participants.....	42
	Data Collection .....	43
	Dependent Variables.....	44
	Operationalization of Dependent Variables.....	45
	Independent Variables .....	49
	Operationalization of Independent Variables .....	49
	Translation of Instruments .....	53
	Data Analysis and Statistical Procedures.....	53
5	FINDINGS .....	56
	Sample Characteristics.....	56
	Findings on Measurement Scales.....	65
	Hypotheses Testing.....	68
	Other Intervening Variables.....	77
	Open-Ended Questions .....	85
6	DISCUSSION.....	90
	Findings of the Study .....	90
	Implications for Social Work Practice.....	98

Implications for Public Policy and Program.....	100
Limitations and Contributions .....	101
Directions for Further Study .....	104
REFERENCES .....	105
APPENDICES .....	126
A The Informed Consent Form .....	126
B Demographic Information .....	128
C Caregiving Tasks .....	130
D Life Satisfaction.....	131
E Social Support .....	132
F Filial Obligation.....	135
G Caregiver Burden.....	136
H Caregiving Satisfaction .....	138
I Self-Rated Health Scale.....	139
J Depression .....	140
K Open Ended Questions .....	141

## LIST OF TABLES

			Page
Table	1	Personal Characteristics of Caregivers .....	57
Table	2	Personal Characteristics of Caregivers .....	59
Table	3	Characteristics of Caregiving Practice.....	61
Table	4	Caregivers' Quality of Relationships.....	62
Table	5	Characteristics of The Elder.....	64
Table	6	Descriptive Statistics for Scales in the Research Model.....	68
Table	7	Comparison of Reduced and Full Models .....	70
Table	8	Results from Final Equation with Caregiving Outcomes and Primary Subjective Stressors.....	71
Table	9	Partial Correlation Coefficients between Filial Obligation and Primary Objective stressor, Primary Subjective Stressors, and Caregiving Outcomes When Controlling for Social Support .....	73
Table	10	Partial Correlation Coefficient between Primary Subjective Stressors and Caregiving Outcomes When Controlling for Social Support	74
Table	11	Correlation Coefficient between Variables in the Caregiving Stress Process .....	77
Table	12	Correlation Coefficients between Four Intervening Variables and Major Variables on the Caregiving Stress Process.....	79

Table 13	Correlation Coefficients between Intervening Variables and Major Variables on the Caregiving Stress Process .....	80
Table 14	Correlation Coefficients between Three Quality of Relationships and Dependent Variables .....	82
Table 15	Summary of Step-Wise Regression Analysis for Variables Predicting Life Satisfaction.....	84
Table 16	Summary of Step-Wise Regression Analysis for Variables Predicting Depression .....	85
Table 17	Reasons to Be Selected As Primary Caregivers .....	86
Table 18	Support from Relatives .....	87
Table 19	Major Problems or Difficulties in Caring for The Elderly .....	88
Table 20	The Major Motives for Caring The Elderly .....	89

## LIST OF FIGURES

	Page
Figure 1	Pearlin's Stress Process Model .....31
Figure 2	The Research Model .....39
Figure 3	The Stress Process Model Based on the Findings of The Study.....92
Figure 4	The Stress Process Model Based on the Findings of The Study.....93

## CHAPTER 1

### INTRODUCTION

Both professionals in the area of aging and children who are caregiving for their elderly parents in Korea have begun to recognize parent care as an important issue.

There is an increasing pressure to understand filial obligations among people in Korea and other Eastern Asian countries (Aimei, 1988; Brody, 1985; Campbell & Kurokawa, 1991; Freed, 1990; Kong, Park, Cho, Kim, & Chang, 1987; Pak, 1985; Sung, 1990; Schulz & Davis-Friedmann, 1987). Although a growing body of literature has identified factors that are associated with providing care for elderly parents, this existing literature on family caregiving largely deals with the impact of caregiving stress on the well-being of the White, middle class families (Haley, West, Wadley, Ford, White, Barrett, Harrell, & Roth, 1995). In spite of the importance of cultural influences, family caregiving has not been examined consistently from different cultural contexts (Lee & Sung, 1998). This concern highlights the necessity for research on adult children caregiving in Korea.

#### Conceptual Framework

Pearlin's stress process model (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995; Pearlin, Lieberman, Menaghan, & Mullan, 1981; Pearlin, Mullan, Semple, & Skaff, 1990) provides a conceptual framework for this study. This stress process framework is chosen to guide the study because it provides the most comprehensive and useful conceptual model for the study of caregiver stress and has been used to predict caregiving

outcomes, such as depression, life satisfaction, and poor health (Aneshensel et al., 1995; Pearlin, 1989; Pearlin et al., 1981; Pearlin et al., 1990).

Pearlin and his associates (1981; 1990) introduce four conceptual domains of the stress process in their framework. First, the concept of background and context includes the potential key characteristics of caregivers such as age, gender, social economic status, family and network composition and program availability. The next conceptual domain is the stressors, which are composed of primary stressors and secondary stressors. In this conceptualization, primary stressors have objective indicators and subjective indicators, which drive the stress process that follows and eventually leads to other stressors. These primary stressors can be found within the caregiving situation. Objective indicators include cognitive status, problematic behaviors, and activities of daily living (ADL) and independent activities of daily living (IADL), dependencies of care recipients, and subjective indicators that include the feeling of being overloaded and relational deprivation of caregivers.

Secondary stressors can be defined as other problems and hardships, which are generated by the primary stressors. Secondary stressors include both role strains and intrapsychic strains. Role strains can be found in roles and activities outside the caregiving situation and are made up of family conflict, job-caregiving conflict, economic problems, and constriction of social life. Secondary intrapsychic strains have both global and situational aspects. Global strains include self-esteem and mastery over the caregiver's life and situational strains include loss of self, role captivity, competence, and gain. These secondary intrapsychic strains involve the dimensions of self-concepts and other psychological states that influence the vulnerability to stress.

The third conceptual domain of the stress process is stress outcomes, which are the highlights of the stress process. The outcomes include depression, anxiety, irascibility, cognitive disturbance, physical health decline, and yielding of roles. The final conceptual domain of the stress process is the moderators. This conceptual framework represents two moderators, coping and social support. Coping is considered as the behaviors and practices of individuals in response to life problems and has three possible functions such as management of the situation, management of meaning, and management of the stress. Pearlin et al. (1990) found that social support inhibits the development of secondary stressors and it is mainly divided into two types of support: instrumental and expressive support.

### Background

Korean cultures are rooted in filial piety where care for the elderly from family and kin is accepted as a customary and normative duty similar to Chinese and Japanese cultures (Broberg, Melching, & Maeda, 1975; Choi, 1989; Choi, 1970; Dixon, 1981; Palmore & Maeda, 1985; Parish & Whyte, 1978; Park, 1983; Schulz & Davis-Friedmann, 1987). Traditional Korean culture has emphasized the obligation of adult children to care for their parents and to meet the needs of elderly parents. This obligation is outlined in Confucian ethics, which includes sacrificing for parent, family harmony, and filial responsibility (Sung, 1994). Within this cultural tradition, it has been generally assumed that the majority of Korean elderly live with their adult children under the extended family structure in Korea. It has been a preferred cultural pattern for elderly parents and adult children to live together and depend upon each other. This pattern of living arrangements reflects the norms and preferences of Korean society (Sung, 1995).



Cultural values are also reflected in the selection of the primary caregiver.

Within the context of Korean cultural traditions of filial piety and Confucian teachings, the eldest adult son is responsible for his elderly parents physically, as well as financially (Choi, 1993; Youn & Song, 1992; Youn, Knight, Jeong, & Benton, 1999). More importantly, Korean cultural norms regarding gender roles suggest that daughters-in-law are the primary caregivers for their parents-in-law (Cho, 1986). Therefore, the eldest daughter-in-law, who is the oldest son's wife, usually has the responsibility for daily care of elderly parents. In descending birth order, other sons and their wives have caregiving responsibility in the absence of the older son and the first daughter-in-law (Lee & Sung, 1998).

However, as in Japan and other East Asia countries, Korea is influenced by the interplay between industrialization and cultural tradition (Hong, 1980), and this social circumstance has altered family structures and functions. For instance, Koreans are living longer as a result of new medical knowledge and technology. The average of life expectancy of Koreans in the 1990s was 71.6 years, well above the age of 60, which was the average only a few decades ago (Soh, 1997). In addition to the increasing population of the elderly, the geographic mobility of adult children, the expansion of the female labor market, the decrease in multigenerational households, and the movement toward smaller families have all impacted traditional ways of functioning (Economic Planning Board, 1986; Gallup-Korea, 1984; Sung, 1991).

These social trends have influenced the traditional ways Koreans think and behave, particularly regarding caring for their elderly parents. For instance, the relationship between elderly parents and adult children is moving from an authoritarian,

patriarchal relationship to an egalitarian, reciprocal relationship involving mutual help and respect (Sung, 1994). This change in relationships creates conflicts between adult children who are primary caregivers and elderly parents in the same household, which impacts perceptions about and patterns of caregiving for elderly parents. In order to reduce generational tensions, which have become increasingly more visible in Korea, changes in parent-child relationships and in the caregiving system structure seem inevitable. For instance, the rate of traditional co-residence among elderly parents is believed to be on the decline from 89% in 1984 to 70% in 1990 and demands for the public to support the elderly are on the increase (Soh, 1997). Eventually, rapid economic development and the accompanying transformations in family structure and life-style will affect the status and well-being of the elderly in Korea (Soh, 1997).

#### Statement of Problem

About three quarters of elderly adults in the United States who need long-term care receive informal support from family and friends exclusively, the remainder uses some combination of formal and informal supports (Doty, 1986). In Korea, the result of one study showed that over 70 % of Korean families share common residence across generations (Sung, 1994), which implies that the major care for elderly parents is provided by families and other informal groups. Because most frail elderly are cared for at home, family caregivers shoulder a significant portion of the care burden/stress. In order to preserve traditional Korean practice and patterns of parent care and/or provide an appropriate statewide formal service for elderly parents, it is necessary to understand issues associated with elderly parent caregiving.

A majority of the existing studies on family caregiving have focused on understanding of the impact of the caregiving experience among White, middle class families. Especially, several caregiving studies have attempted to include the idea of filial obligation, which is bound to cultural norms and contexts to look at caregiving outcome in Western culture (Brickman, 1987; Cantor, 1983; Cicirelli, 1983; Horowitz & Shindelman, 1983). However, little is known about the role of filial obligation in the caregiving stress process of caring for elderly parents in the oriental culture much less Western culture. The inclusion of filial obligation in understanding the caregiving stress process is especially important given that there is limited information about the impact of caregiving by culture (Dilworth-Anderson & Anderson, 1994). Without considering cultural background, it is difficult to identify caregivers' experience in Korea. Therefore, it is necessary to include the concept of filial obligation in exploring the caregiving process for Korean daughters-in-law who are providing care for their parents-in-law. Including this concept can provide a better understanding of the impact of the caregiving process in Korea.

#### Purpose of the Study

This study will investigate to what extent filial obligation is related to the variables in the caregiving process and describe the relationships among the variables of caregiving for daughter-in-law caregivers for elderly parents in Korea. Specifically, the hypotheses that were tested in this study derive from the proposed conceptual framework and the significance of the problem. These hypotheses are:

1. The proposed stress process model, which includes filial obligation as a background and context variable, better predict primary subjective stressors (which are caregiving

- satisfaction and caregiving burden) and caregiving outcomes (which are life satisfaction and depression) than the model without filial obligation.
2. The background and context variable, filial obligation is positively related to the primary objective stressor, caregiving tasks, and the primary subjective stressor, caregiving satisfaction, as mediated by social support, while it is negatively related to the other primary subjective stressor variable, caregiving burden when controlling for social support.
  3. The background and context variable, filial obligation, is related to caregiving outcomes (depression and life satisfaction) as mediated by social support. Filial obligation is positively related to life satisfaction, yet, negatively related to depression when controlling for social support.
  4. There are the relationships between the primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (depression and life satisfaction) as mediated by social support. Caregiving satisfaction is positively associated with life satisfaction, yet, negatively associated with depression. In addition, caregiving burden is positively associated with the level of depression, yet, negatively associated with life satisfaction.

#### Significance of the Study

Korea has undergone dynamic social change in the process of rapid industrialization and urbanization and the public has paid increased attention to care for the elderly (Sung, 1991). Korea has successfully expanded its social welfare institutions; however, it is unlikely that the formal system will keep pace with the growing needs of small families in an industrialized and urbanized society (Moroney, 1976; West, 1984).

In this context, Korean society recognizes the importance of the informal social support system and the ability of the family as an informal caregiving institution that must be supported (Sung, 1994).

Since little has been written about informal support for elderly parents in Korea (Sung, 1994), information from this study will provide a better understanding of the experience of Korean adult children caring for elderly parents. Specifically, the results of the study will demonstrate how filial obligation has an impact on the caregiving process in Korea. Therefore, the findings in this study will benefit policymakers, researchers, gerontological social workers, and other human service providers in Korea, who may in turn, influence renewed societal commitments to the elderly caregiving process, especially support of caregivers for the elderly.

Understanding how both the caregiving process and filial obligation affect caregiving daughters-in-law's psychological and physical health is important for future social service development. Social service providers or social workers may also benefit from the findings of this study, by gaining a greater understanding of the need for appropriate service to daughters-in-law who provide care for their elderly parents-in-law. For instance, service providers may provide support services for caregiving daughters-in-law in one situation, but may recommend institutional care for the elderly in another situation. If factors such as psychological well-being, physical health, social support, and demographic characteristics like age, and the social economic situation of caregiver are known to be impacted by caregiving, it may be possible to better tailor services to individual situations. In addition, caregiving daughters-in-law themselves may benefit from understanding the various factors related to caregiving and the problems, which

may result from providing assistance to the elderly. For instance, understanding a variety of roles of family caregiving may make it possible for caregiving daughter-in-laws to prepare affordable supports and positive strategies to meet the high demands of caregiving.

## CHAPTER 2

### LITERATURE REVIEW

The dramatic expansion of the elderly population in Korea, as well as in the world, is a relatively recent phenomenon, which has ramifications throughout society. According to the 1990 Korean census, 3,320, 000 people are defined as people of 60 years of age or older, and in ten years this population has tripled ( HankukIlbo, June 19, 1993). The growth in the size of this population implies that increasing numbers of the elderly are at risk for becoming dependent upon others for some type of assistance. Existing empirical information pertinent to the caregiving experience has been derived predominantly from investigations within the context of white American culture where individualism and independence are construed as social norms (Choi, 1993; Hinrichsen & Ramirez, 1992; Raveis, Siegel, & Sudit, 1990; Sung, 1994). Whether the findings of previous research hold across different cultures is still questionable; therefore, it is important to understand the experience of caregivers in their own cultures.

This literature review will provide a context within which to consider the experience of adult children caregivers for elderly parents in Korea. Several issues will be explored: What is the nature of caregiving for the elderly in the U.S. and Korea? What is the function of cultural norms of caregiving in the U.S. and Korea? What changes are occurring in the cultural norms around caregiving in Korea? What do we know about the experiences of caregivers in Korea? The present chapter will present a

literature review that will lead to the conceptual framework for the study, which will be presented in Chapter 3.

#### Nature of Caregiving in the U.S.

Several studies suggested that families are the main source of care for the elderly, providing multiple forms of support and assistance, for example, medically related care, personal care, household maintenance, transportation, and shopping (Connidis, 1994; Gallagher, 1994; Lee, Netzer, & Coward, 1994; Rossi & Rossi, 1990; Stone, Cafferata, & Sangl, 1987; Walker & Pratt, 1991). Studies showed that nearly 80% of elders receive care from informal sources, while fewer than 10% receive care from formal sources in the U.S. (Berg-Weger, 1996; Doty, 1986; Stone, Cafferata, & Sangl, 1987). Almost 5.1 million elderly living in the community receive help from informal caregivers (Gevalnik & Simonsick, 1993) and approximately 10 million adults in the U.S. are giving care to an elderly relative (Toseland, Smith, & McCallion, 1995). Estimates of the number of caregivers vary from 2.2 million to 13.3 million individuals, depending on how caregiving is defined (Stone et al., 1987; Stone & Kemper, 1989).

Berg-Weger (1996) defined family caregiving of the elderly as “one or more family members giving aid or assistance to other family members beyond that required as part of normal everyday life”(p.4), which is a result of a need by the elder placed on another individual. One major caregiver, commonly referred to the primary caregiver, provides most of the caregiving. This is the key person responsible for the care of the older individual. Primary caregivers typically devote the most hours to care, provide the widest range of services, and take on the weight of responsibility for the delivery of care.



An earlier study showed that spouses make up 42% of the population of primary caregivers, and adult daughters another 29% (Stone et al., 1987).

#### Nature of Caregiving in Korea

Historically, the normative and practical residence pattern in old age has been the co-residence of aged parents with married children, particularly the eldest son and his family (Kim & Rhee, 1997). For instance, over 70 percent of Korean families share common residence across generations (Sung, 1994). Along with the dramatic and sweeping social changes over the past decades, the actual residence patterns of the elderly in Korea have shifted from co-residence with children to separate residence. National statistics demonstrate a drop from 32.2% in 1986 to 15.7% in 1990 in the proportion of stem family households (composed of two married couples of different generations or a single parent and married children) headed by persons aged 60 and over. Regarding preferred living arrangements, the proportion of the elderly desiring coresidence with children decreased from higher than 70% during the early 1980s to 47% in 1994 (Korean Gallup Survey, 1981; Survey on the Aged Population in Korea, 1984; Survey on the Living Conditions of the Korean Elderly, 1994 as cited in Kim & Rhee, 1997). In addition, 26% of the Korean elderly lived in either a single-person household or a conjugal couple household without informal or public supports (Soh, 1997).

In the co-residential living arrangement, the question of who will be in the decision-making position concerning the daily management of elder care is a major source of social psychological conflict between mother-in-law and daughter-in-law. In fact, this type of psychological conflict between mother-in-law and the daughter-in-law seems to be at the root of the problem when they co-reside. Specifically, the conflicts

could be more severe and serious when a personality clash, intergenerational conflict in values and life styles occur in the same household. Notably, seven out of ten respondents to a survey conducted by Korea Gallup (1990) replied that the conflict between mother-in-law and daughter-in-law was a serious problem in family relations in contemporary Korean society. Therefore, caregivers and care-recipients who were involved in the conflict situation, providing care for the elderly in the same household tends to have a negative impact on both caregiving daughters-in law and care receiving elderly. However, there is no empirical evidence to support or refute that co-residence has a negative impact on daughters-in-law's caregiving experience.

#### Caregiving with Cultural Norms

Caregiving for elderly parents cannot be separated from the cultural norms and values in Korean society. Mainly, the selection of the primary caregiver and motivation of caregiving will be discussed in conjunction with cultural norms and values.

#### Selection of primary caregiver

Previous research on the impact of cultural factors on the caregiving stress of Korean adult children identified notable differences in cultural characteristics associated with caregiving context (Lee, & Sung, 1998; Sung, 1994; Sung, 1990). Korean cultural norms regarding whose family is going to be the primary family for providing care for elderly parents are specifically defined. The patriarchal system supported by Korean tradition has imposed the notion of caring only for parental relatives as natural, so a married daughter has been expected to transfer her devotions to her husband's family members. Therefore, the first son and his wife were expected to take care of his parents in Korea. Daughters-in-law are usually the primary caregivers for the parent-in-laws

according to Korean gender roles (Cho, 1986; Choi, 1993; Sung, 1994). In Korean culture, if a dependent parent-in-law becomes a widower, the first daughter-in-law is expected to assume the caregiving role for the in-law. If the elder were male and married, his wife would be the first source for care; the first daughter-in-law would be expected to provide the elderly couple with considerable support. Other children and their wives would fill the same role in the absence of the first daughter-in-law (Choi, 1993; Lee & Sung, 1998). Therefore, it is absolutely necessary to have sons in the household, in connection with the cultural norms of the responsibility of the first son to support his parents in their old age (Choi, 1993).

On the other hand, U.S. cultural norms showed that when an elder family member needs care, caregiving is most often provided by a spouse (Himes, 1994; Hirschfeld, 1983). If a spouse is not available, an adult daughter, an adult son, or other relatives such as a daughter-in-law, the care recipient's siblings, granddaughters, or friends, and other relatives are most likely to provide care (Himes, 1994; Shanas, 1968; Smith, 1995; Tonti, 1988). Specifically, biological adult daughters are more likely to provide care to parents than sons, and because women tend to live longer than men, daughters are in large part caring for elderly mothers (Himes, 1994). However, even in families in which a primary caregiver is designated, additional support is often provided by siblings (Noelker & Townsend, 1987; Smith, 1995).

Despite cultural difference, research on caregiving consistently finds that the majority of caregivers are women (Choi, 1993; Himes, 1994; Sheehan & Donorfio, 1999; Soh, 1997; Sung, 1994). While American culture expects biological daughters who tie by blood to be primary caregivers for parents, Korean culture expects daughters-in-law who

tie by law. Relationships between in-laws are obviously different from that of blood relations. Fischer (1986) argued that the relationship between in-laws lacked the familiarity and intimacy of the mother-daughter relationship because of a shorter shared history and indirect linkage. Mothers and daughters are also involved emotionally more than in-laws. While relationships between in-laws vary from being strangers to being almost mother-daughter bonds, relationships between mother and daughter are solid and unchanged (Merrill, 1997). The selection of primary caregivers in these two cultures indicates the difference in the nature of primary caregivers, which may affect the level of involvement and commitment of a caregiver in caregiving process. Thus, caregiving experiences of primary caregivers are different in these two cultures.

#### Caregiving with cultural values

Korean cultural norms and values enhance the distinctive difference in the motivations for elderly parent care in Korea versus the U.S. The moral ideal in traditional values in Korea associated with the care of elderly parents is that elderly people should be respected and cared for as they are the ones who have suffered to raise a new generation and who have contributed to their family and society in past years (Soh, 1997). Korean cultural values have lectured that elderly parents should live in extended families with children and grandchildren (Lee, Kim, & Lee, 1999; Lee & Sung, 1998; Sung, 1994). In Korea, cultural traditions rooted in filial piety dictate that children are taught to think of the family first, and are expected to respect their parents and be responsible for them in their old age. As a result, Korean children place considerable emphasis on their obligations and commitments to the family, and value and respect the wisdom of the elderly.

These Korean cultural norms and values directly influence the types of policies, programs, and services for care of the elderly. The responsibility of adult children to provide care and support for elderly parents is not only morally sanctioned but also legally binding. Current Korean law stipulates the obligation of adult children to support their elderly parents when parents cannot support themselves (Soh, 1997). In addition, the social welfare system is still in the process of development, and public or private in-home and residential services are not yet widely available in Korea (Sung, 1993). Government-funded services that provide support for families caring for elderly persons are also limited. Therefore, long-term care responsibilities rest primarily on the family, so Korean elderly interact more frequently with their extended kin and receive a greater amount of care and support from them (Lee & Sung, 1998; Sung, 1994). For instance, the Korean Institute of Gerontology (1993) reported that more than 70% of Koreans aged 60 believe living with sons and grandchildren is the most comfortable and reputable life. Extremely low utilization of elderly long term care facilities is also indicative of the Korean attitudes about multigenerational living arrangement. Only 0.3% of Koreans aged 65 or more live in nursing or retirement facilities and more than 50% live with children, while more than 10% live in the facilities but mostly live apart from children in the U.S. (Korean Institute of Gerontology, 1993).

In America, from an early age, children are exposed to the value of independence and personal freedom (Spence, 1985). The culture is very “youth” oriented. When adult children are confronted with family obligations and the need to care for elderly parents, it is often stressful (Jarret, 1985). People are oriented toward a more self-centered life style, therefore; societally, they have a greater variety of public services

available, and extended family support seems to be minimal (Sung, 1994). Despite this cultural orientation and life style, a large percentage of American adult children believe that the elderly should be able to depend on their children for assistance when need and caring for a parent out of a sense of family obligation was mentioned as the primary reason for providing care in caregiving research (Horowitz & Shindelman, 1983).

However, caregivers and care-receivers may have different views of the extent to which obligation serves as a motivation for care. For instance, Walker, Pratt, Shin, and Jones (1988) reported that over 69% of caregiving daughters describe some degree of obligation in caring for their mothers, while less than 30% of the care-receiving mothers felt that their daughters were providing care out of a sense of obligation. There appears to be some ambivalence surrounding the obligation of adult children to care for a frail parent. General feelings about the obligation of adult children to care for parents are likely to be different from feelings about a sense of obligation to care for one's own parent. While general feelings of obligation include a broader, normative statement, direct feelings of obligation are addressing the caregiver's own reality.

When adult children provide care for their elderly in the same household, the well-being of the caregiver primarily relies on his or her parents, while the well-being of the elderly relies on the levels of involvement and commitment of family caregivers unless the individual relies totally on paid services. Understanding direct feelings of filial responsibility/obligation is especially important, because it tends to determine the level of involvement and commitment of a caregiver, affecting the amount and quality of care provided. It is also likely to influence how the caregiver perceives the caregiving situation. Therefore, the level of direct feelings of filial responsibility/obligation may

vary the effects of caregiving on the caregiver's well-being (Lee, 1999). In this study, caregiving daughters-in-law's direct feelings of obligation toward their elderly in Korea are focused to provide the caregiving daughters-in-law's real feelings of obligation under their own caregiving situations.

Several studies identified motivating factors for daughters' providing care for their elderly parents (Merrill, 1997; Moen, 1994; Silverstein, Parrott, & Bengtson, 1995; Suito, Pillemer, Keeton, & Robison, 1995). Merrill (1997) found that the common motivating factor for providing care was a sense of obligation or reciprocity, while other researchers found intergenerational affection was an important factor motivating daughters (Silverstein et al., 1995; Suito et al., 1995). However, Walker (1996) argued that those motivating factors such as reciprocity, affection, and obligation are more likely secondary factors, which motivated caregiving daughters to continue providing care. The study showed that the primary motivation for daughters to become caregivers was the belief that it was their role. This belief is obviously influenced by external normative structures or cultural expectations.

These variations in social norms, values, and customs are likely to produce different responses from family members providing care for elderly parents. In addition, the selection of primary caregivers is different in these two cultures, thus the bonds between caregivers and care recipients are different. Fischer (1986) argued that while mothers and daughters were linked from the time of birth, in-law relationships have less familiarity and intimacy due to a shorter history of marriage and family relationships. However, despite culturally different orientations, Sung's (1994) cross-cultural study

showed that responsibility, obligation, affection, and reciprocity were common motivations of adult children caregivers for elderly parents in both the US and Korea.

Few caregiving studies have attempted to link filial obligation with other caregiving variables such as caregiving burden (Brickman, 1987; Cantor, 1983; Cicirelli, 1983; Horowitz & Shindelman, 1983; Roberts & Banahan, 1988). For instance, Cantor (1983) used a general measure for filial obligation in elderly parent caregiving and found a positive relationship between filial obligation and caregiver strain. In addition, Cicirelli also (1983) found an indirect positive relationship between obligation and negative feelings toward caregiving. Horowitz and Shindelman (1983) reported a positive relationship between obligation and affection, between the caregiver and the care recipient, and Roberts and Banahan (1988) also found affection was the variable most consistently related to adult children's specific filial obligations toward their parent.

In this study, a specific measure of direct feelings of obligation is used, while feelings of the general obligation of adult children to care for aging parents are collected through an open-ended question.

### The Change in Cultural Norms on Caregiving in Korea

#### The change of cultural norms

Korean culture has been influenced by the indigenous religions of Shamanism and Taejonggyo, imported religions of Taoism and Buddhism, and the philosophy of Confucianism (Lee, 1995). Shamanism and Taoism believe that nature and people are inseparable and all forms of life in the universe are interconnected. Taoism emphasizes beliefs in harmony, patience, contentment, and simplicity, which are central to Korean culture. Buddhism stresses the importance of strength in overcoming difficulties,



endurance of pain, and calm in the face of difficulties. Confucianism emphasizes the importance of love and loyalty to parents, honoring both community and the world beyond (Drachman, Kwon-Ahn, & Paulino, 1996). Confucian teaching on filial piety is considered the key to an orderly family and society (Drachman et al., 1996). This belief system still governs the family system and manners of daily living in Korea (Sung, 1990). The basic components of filial piety are love and respect toward parents inherent in the child-parent relationship (Li, 1987). Filial piety includes all kinds of services to one's parents. Three important conditions for filial piety are as follows: respecting parents, bringing no dishonor to parents, and taking good care of parents (Li-Chi, 1885). Finally, the idea of filial piety has to be imbued with respect and love and one way of practicing the idea of filial piety is adult children taking care of elderly parents within the same household.

In addition to the concept of filial piety, based upon Confucianism as well as ancestor worship, the concept of a vertical society is important to Korean culture. Seniority would be a decisive factor in determining the relative hierarchy which leads to the particularly high status of the elderly in Korean society as a whole and in many segments of life in particular. Ancestor worship occupies a prominent place in Korean culture. Because the aged are the ones who are nearest to the ancestor and they in fact will, within a short term, be themselves ancestors, ancestor worship is seen to contribute to the high position of the elderly. For instance, ancestor worship stems from an overall respect for the elderly whose knowledge was of primary importance for the survival of the community (Formanek & Linhart, 1997).

The social status of the elderly was enviably high in traditional Korea, where a gerontocracy unabashedly practiced ageism, slighting the young and esteeming the old. Therefore, when parents are at the age when they can no longer take care of themselves, it is only right that they should be cared for by those whom they themselves have raised (Sung, 1990). Recently, forms of respect for the elderly have slowly changed in Korea, as the female labor market expands, multigenerational households decrease, and the young tend to emphasize a more individualistic lifestyle (Sung, 1990). The idea of respect for the elderly has become a public issue in Korea because the society has undergone great change. There is concern about the impact that a lack of filial piety will have on the welfare of elderly people in Korea.

### Modernization

Families in contemporary Korea struggle with conflicts between their commitment to care for elderly family members according to early 20<sup>th</sup> century expectations and the realities of changed resources and values as Korea enters the 21<sup>st</sup> century (Soh, 1993). For instance, the average life expectancy of Koreans in 1991 was 71.6 years in 1991, which was a 19-year increase over a 30 year period (Soh, 1997). Longer life expectancy means that some families may experience many years burdened with the care of their elderly relatives who may have potentially serious physical and cognitive impairment. Greatly increased life expectancies, together with other demographic, economic, and social realities of late 20<sup>th</sup> century Korea, have made the ideal of family caregiving more difficult to realize (Sung, 1994).

Social phenomena such as economic development, urbanization, and geographic mobility are important indices of modernization relevant to the issues of the status of the

Korean elderly. Cowgill (1986) stated that the more advanced the economy of a society, the lower the status accorded its elderly citizens. In Korea, extensive urbanization and industrialization, which are strongly related to the breakdown of traditional notions of marriage and the family, have accompanied the rapid economic development that has occurred since the 1960s. About three-quarters of the population in Korea now live in urban areas and young people migrate to urban areas in search of industrial jobs. This phenomenon has resulted in the allocation of occupational roles to younger workers (Silverstein, Burholt, & Bengtson, 1998). In addition, rapid economic development demands that adult children pursue more knowledge and higher levels of specialization to keep up with the job market, which causes them to move away from their families in order to maximize their educational and occupational attainment. However, elderly parents stay in the rural areas or move away from urban area in favor of more rural retirement communities (Silverstein et al., 1998). Thus, the ratio of the elderly in the rural population is much greater than that among the urban population. This mobility has resulted in greater geographic separation between generations and the decline of traditional patterns of parent care.

Another aspect of the decline of intergenerational family is new values and attitudes brought by modernization. Korea has changed from a traditional agrarian society under colonial rule to a newly industrialized democratic nation within the life-time of the current generation of the elderly. Cowgill and Holmes (1972) argued that new ideas and technologies and greater mobility undermined traditional values and attitudes, resulting in the loss of status among the elderly in industrial societies. Many young people, particularly of working-class backgrounds who migrate from rural to urban areas in

search of jobs, choose their marital partners on their own instead of marrying spouses selected by their parents. In contrast to the traditional postmarital residence, it is common today for young couples to live separately from the husbands' parents after marriage. Moreover, the emotional bonding between husband and wife in a nuclear family household is increasingly being emphasized as an essential element for a happy marital life. This emphasis directly challenges the traditional stress on the paramount importance of filial piety for adult children toward their aging parents living together in a generational co-residential household. Thus, the issues of living arrangements for the elderly and the support and care for them represents prominent aspects of changing family life, which offers insights into the status of the elderly in contemporary Korean society.

However, there is no doubt that the majority of Koreans still regard it as only natural for adult children to take care of aging parents (Soh, 1993). For instance, a study was conducted with 980 young Korean men aged between 27 to 34. The study found that 90% of subjects believed that aged parents should be taken care of by the family or the eldest son and 13.7% said that it should be the common responsibility of kinsmen, while only 7.5% responded that the government should take care of the elderly (HankukIlbo, March 29, 1994). These findings indicated that the duty of filial piety regarding taking care of aging parents remains prominent among Korean youth, in spite of a change of society.

#### Caregiving Experiences

Families play an important role in the lives of the elderly especially those who are frail, because of their impairments and need for assistance. Since most frail Korean

elderly receive family-based assistance for caregiving, issues concerning the caregiving experience of the primary caregiver have been explored. Several studies have examined the experience of caregivers in the caregiving process (Himes, 1994; Merrill, 1993; Mui & Morrow-Howell, 1993; Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999; Sheehan & Donorfio, 1999).

### Caregiving tasks

Caregiving tasks can be defined as an actual involvement of the caregiver in caregiving. Although it has not always been included in caregiving studies, examining caregiving tasks is an important factor to consider in any caregiving study. Involvement in caregiving varies greatly from caregiver to caregiver as the level of caregiving burden varies greatly. Previous studies reported that the involvement of caregiving tasks directly impact the caregiving outcomes (Cantor, 1991; Choi, 1993; George & Gwyther, 1986; Horowitz, 1985; Merrill, 1993; Miller, McFall, & Montgomery, 1991; Pallett, 1990; Stommel, Given, & Given, 1990; Stone, Cafferata, & Sangl, 1987). For instance, physical demands, demands on time, and financial concerns were found to be the most difficult problems faced by caregivers (Strawbridge, 1991). Therefore, caregiving tasks concerning the number of tasks performed and time actually spent on care recipients are important issues in elderly caregiving. This study will examine both actual tasks performed and the frequency of performance in a typical caregiving week.

### Caregiving burden/strain

A growing body of previous research of caregiving reported that about half of the caregiving families surveyed reported differing levels of burden; however, results varied widely (Choi, 1993; Strawbridge, 1991). While some studies reported few

burdens, others reported relatively high levels (Montgomery, Stoll, & Borgatta, 1985; Wallhagen, 1990). Several researchers attempted to obtain a better explanation of the difference in caregiving stress levels (Dilworth-Anderson & Anderson, 1994; George & Gwyther, 1986; Haley et al., 1995; Otten, 1989; Richardson & Sistler, 1999; Whittick, 1988). For instance, George and Gwyther (1986) compared a non-caregiving group with a group that was caregiving for Alzheimer patients; this group of caregivers reported a greater relative burden. A similar group of caregivers was also found to experience a higher rate of illness than a non-caregiving control group (Otten, 1989). Adult females, who provide care for a demented parent experience more emotional distress than do mothers caring for children with retardation (Horowitz, 1985; Whittick, 1988).

Depression, illness, low life satisfaction, and perceived burden have been studied as important aspects of caregiver burden. Most studies on caregiving suggested that caregivers experience psychological distress including anxiety, hostility, obsessive-compulsive symptoms, and hysteria, while some studies have found that caregivers have higher scores on standardized depression inventories and higher prevalence of depressive diagnoses than population norms or noncaregiving comparison populations (Dura, Stukenberg, & Kiecolt-Glaser, 1990, 1991; Fuller-Jonap & Haley, 1995; Haley et al., 1995).

A few studies provided preliminary evidence of caregiving's impact on health behaviors and suggested that caregivers have poorer health in comparison to either non-caregivers or normative data (Burton, Newsom, Schulz, Hirsch, & German, 1997; Connell, 1994; Fuller-Jonap & Haley, 1995; Gallant & Connell, 1998; Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991). For instance, a study showed that most

caregivers indicated using eating and sleeping as coping strategies and the others implied eating less nutritiously. Some exercisers reported being less active and half of the smokers reported smoking more since caregiving began (Connell, 1994). Gallant and Connell (1998) also found that the caregiving stress process negatively influences caregiver health behaviors. Other studies also demonstrated that getting adequate sleep and maintaining regular exercise are significantly more difficult for caregivers than for non-caregivers (Burton et al., 1997; Fuller-Jonap & Haley, 1995). However, the domains of health affected by caregiving are not consistent across studies. Due to methodological problems, several researchers (Haley et al.; 1995; Killeen, 1990; Schulz, Visintainer, & Williamson, 1990) suggested that major questions remain regarding whether caregiving affects physical health.

#### Caregiving satisfaction

Caregiving satisfaction is defined as perceptions on the part of the caregiver that certain aspects of providing care are beneficial to the caregiver and his/her family (Strawbridge, 1991). While the emphasis of caregiving research has been on caregiving burden, caregiving satisfaction has not been studied until recently (Kramer, 1997; Miller & Lawton, 1997; Strawbridge, 1991). However, even caregiving burden/strain research has demonstrated that caregivers reported some aspects of their caregiving experience were positive (Chenoweth & Spencer, 1986; Farran, 1997; Horowitz, 1985; Kramer, 1997; Kinney & Stephens, 1988; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991; Miller, 1989; Murphy, 1990; Stephens, Franks, & Townsend, 1994; Stuckey, Neundorfer, & Smyth, 1996). For instance, caregivers who rated high levels of burden reported positive elements in their caregiving experiences, such as an improved sense of self-

worth or growing closer to the care-recipient (Horowitz, 1985; Lawton et al., 1991; Miller, 1989; Kinney & Stephens, 1988; Murphy, 1990; Stephens et al., 1994).

Kramer (1997) introduced the term “gain” to address the more positive appraisals of the caregiving experience. While stress (or burden) has been defined as “the extent to which the caregiving role is judged to infringe upon an individual’s life space and (to) be oppressive” (Montgomery, 1989, p. 204), gain may be defined as “the extent to which the caregiving role is appraised to enhance an individuals’ life space and be enriching” (Kramer, 1997, p. 219). Miller and Lawton (1997) addressed the importance of recognition of positive aspects of caregiving, even though the stress process model showed no predictive power for understanding caregiver gain.

While finding satisfaction in difficult circumstances could be simply a form of meaningful consequences, caregiving satisfaction could also impact caregiving outcomes. However, caregiving research, which addresses the relationship between caregiving satisfaction and its consequences, has had mixed results. Earlier studies on caregiving have guided the assumption that caregiving burden and stress are negatively related to caregiving satisfaction. Studies have addressed the interrelationship between satisfaction and stress as one element in the continuity of care of family caregivers (Brody, Litvin, Hoffman, & Kleban, 1992; George & Gwyther, 1986; Kramer, 1997; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991; Miller, 1989; Stuckey, Neundorfer, & Smyth, 1996). Some studies found that satisfaction with caregiving is not the inverse of burden or stress, and satisfaction is not associated with most characteristics of the care receiver, the caregiver, or the social support of the caregiver (Moss, Lawton, Dean, Goodman, & Schneider, 1987). Miller (1989) and Lawton et al. (1991) conducted studies, which



investigated caregivers' satisfaction. Miller (1989) used a subsample of adult children caregivers from the 1982 National Long Term Care Survey and Lawton et al. (1991) conducted a study with 285 family caregivers. Both studies showed adult children most involved in the caregiving experience report both high stress and high satisfaction, and satisfaction was not related to caregiving stress/burden.

Thus far it seems clear that satisfaction is a common experience in the caregiving process; however, the relationship it may have to caregiving outcomes is not clear. Without examining the effects of caregiving satisfaction with other variables, it is impossible to find out if this variable makes any contribution to caregiving outcomes. Therefore, this study will examine caregiving satisfaction independently with other variables.

### Social support

House, Umberson, & Landis (1988) defined social support as the functional aspects of social relationships that are positive and potentially stress-reducing, such as the emotional caring and concern a close relationship can provide, or the instrumental assistance and information others can offer. To understand social support that is both available and positively received, an examination of the content of caregivers' social relationships is necessary, because not all relationships provide similar kinds of support. Social activity refers to caregivers' participation or involvement in social activities (Haley et al., 1995). Investigating caregivers' social activities helps to specify the degree of social integration/isolation experienced and which family, relatives, and friends are available to offer support.

Little is known about the dimensions of social support affected by caregiving (Haley et al., 1995). In addition, earlier studies have indicated inconsistent findings between caregiving experience and social support and social activity. Empirical evidence suggested that social support lessens the costs of caregiving and ameliorates caregiving burden/stress (Dunkel-Schetter & Bennett, 1990; Pearlin et al., 1990; Thompson, Futterman, Gallagher-Thompson, Rose, & Lovett, 1993; Zarit, Orr, & Zarit, 1985). On the other hand, other studies found that social support is not positively associated with caregiving experience and/or some personal relationships are not supportive at all (Clipp & George, 1990; Strawbridge & Wallhagen, 1991; Thompson et al., 1993; Youn et al., 1999).

One of the reasons for this difference may be the fact that different studies measure different aspects of social support (Stuckey & Smyth, 1997). George (1996) argued that the amount of support and satisfaction with support have to be examined separately. For instance, most of the research has suggested that perceived adequacy and satisfaction with social support are stronger predictors of caregivers' health outcomes than is the amount of support (Cutrona & Russell, 1990; Stuckey & Smyth, 1997; Wellman & Wortley, 1990). However, research on caregiving burden/stress associated with social support found that the types of social support correlated with different relationships to caregiving burden/stress (Thompson, Futterman, Gallagher-Thompson, Rose, & Lovett, 1993).

Previous research findings on caregiving indicated that the caregiving process impacts the psychological and physical health of care providers and their caregiving burdens/stresses are correlated with the level and type of social support (Haley et al.,

1995; Stuckey et al., 1997; Thompson et al., 1993; Youn et al., 1999). However, these findings were within the context of Western culture; therefore, whether these findings hold across different cultures especially like South Korea is unknown. In order to examine the relevance of these findings in Korean culture, the study will assess the psychological and physical health and social support of the caregiving daughters-in-law.

#### Summary

This review of literature provides both the context for considering daughters-in-law who provide care for parents-in-law in Korea and the impact of the caregiving process. The Korean traditional way of providing care for elderly parents has begun to be recognized as a social issue along with changes in social and economic conditions. Little is known about the change of cultural values and caregiving process of daughters-in-law for their elderly parents-in-law in Korea. To provide appropriate services to both the elderly and their family caregivers, societal understanding of the family caregiving process will be necessary.

## CHAPTER 3

## CONCEPTUAL FRAMEWORK

Pearlin's stress process model (1981, 1982, 1985, 1990) provides a conceptual framework for this study (see figure 1). Pearlin and associates (1981,1982, 1990) defined stress as a response of an organism to conditions that are experienced, consciously or unconsciously, and as noxious. They believed that caregiving is potentially a fertile ground for persistent stress.

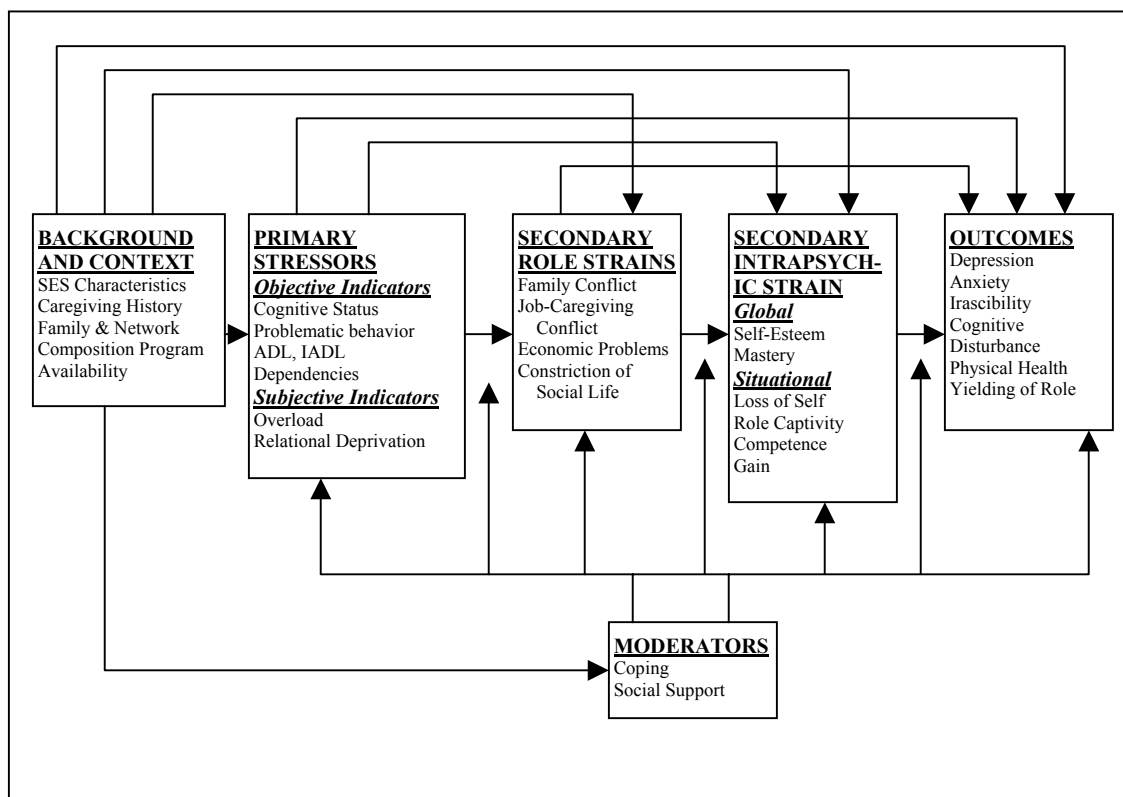


Figure 1. Pearlin's Stress Process Model

This conceptual model perceives caregiver stress as a consequence of a process comprising a number of interrelated conditions, which have been referred to as the stress process by considerable exploratory research among spouses and adult children who care for the frail relatives (Pearlin et al., 1990). This model focused on both identifying conditions associated with stress and providing the development and change of relationships within the identified conditions.

This model describes four conceptual domains of caregiving stress, each with multiple components. These domains are the background and context of stress, the source of stress, the moderators of stress, and the outcomes of stress. Each domain will be further described.

#### Background and Context of Stress

Pearlin et al. (1990) reported that almost everything about caregiving and its consequences is potentially influenced by the key characteristics of the caregiver. They give as examples ascribed status, age, gender, ethnicity, educational level, work history, and economic status. Other background variables include family and network composition, program availability and the history of caregiving. Pearlin et al. (1981) also suggested that the quality of a stressful event (e.g., voluntary or involuntary or desirability of the event) and schedule of events (whether they were scheduled or unscheduled) are important contextual elements to be considered. Pearlin and associates (1990, 1981) stated that the relationship between social and economic characteristics of caregivers and other variables of the stress process are very important. Even though the stressors to which caregivers are exposed and the resources caregivers possess are similar, outcomes caregivers experience may vary with the social and economic characteristics of

the caregivers. Therefore, the socioeconomic and demographic contexts of caregiving are a part of the stress process that may have an impact on stress outcomes.

Jarrett (1985) also found that the motivation for caregiving could be an important background factor. For example, altruistic motives may not be necessary, but they may change the context of caregiving and make it less stressful. Links between social and economic characteristics of caregivers along with cultural values, norms and customs have been recognized as important components of the caregiving stress process. Several researchers examined cultural influences on the caregiving stress process and identified culturally specific values, norms, and customs associated with low or high stress in caregiving adult children (Lee & Sung, 1998; Choi, 1993; Youn, Knight, Jeong, & Benton, 1999). These studies indicated needs for culturally-appropriate interventions for caregivers that imply that the validity of the findings with one type of caregiver population such as white middle class persons in Western culture may not be applicable to another cultural group, such as Koreans in East Asia.

#### Sources of Stress

Pearlin et al. (1990) defined a stressor as a condition, experience, and activity that is problematic for people, which may threaten them, thwart their efforts, fatigue them and defeat their dreams. Pearlin et al. (1981) proposed that stressors arise from two broad circumstances, which are the occurrence of discrete events (eventful experience) and the presence of relatively continuous problems (life strain). Life events that are likely to arouse stress may create new strains or may exert their effects through preexisting chronic strains. In fact, life events stand as a potential cause that eventuates in stress whether life strain creates new strain or intensifies chronic life strains. Life

events and strain are more likely to produce stress when they result in a diminishment of the self concerning mastery and self-esteem (Pearlin et al., 1981). Mastery involves the extent to which people see themselves as being in control of the forces that importantly affect their life. Self-esteem refers to the judgments one makes about one's own self-worth. Stress provoking life events and persistent life strains may cause people to become vulnerable to the erosion of mastery and to the loss of self-esteem. This diminishment of the self can be viewed as the final stage in the process of producing stress (Pearlin et al., 1981; Pearlin & Lieberman, 1979).

Pearlin et al.(1981, 1990) identified stressors as primary and secondary. They consider the primary stressor as driving the stress process. In the caregiving process, the primary stressors come directly from the needs of care recipients and the nature of the care demanded by these needs. For instance, Pearlin et al. (1990) suggested some indicators of the primary stressors, for example, the cognitive status and the problematic behaviors of care recipients, the surveillance, control, and work required by the caregiver, and daily dependencies. These primary stressors are objective indicators of stressors in the sense that they can be measured based on the functional condition of care recipients. In addition, primary stressors also include subjective indicators such as overload or burnout felt by caregiver and as well as relational deprivation.

Secondary stressors are other problems and hardships that arise as a result of primary stressors, which are the original set of hardships (Aneshensel et al., 1995). The term primary and secondary are not directly related to their capacity to produce stress. Once secondary stressors are established they can be more powerful than the primary stressors in producing stress outcomes (Aneshensel et al., 1995; Pearlin et al., 1990).

While primary stressors involve stressors that originate within the provisions of caregiving itself, secondary stressors give attention to difficulties that generate from caregiving, but are not directly involved in the boundaries of care (Aneshensel et al., 1995).

Secondary stressors can be divided as role strains and intrapsychic strains. First, role strains are those strains found in roles and activities outside the caregiving situation. They include such things as family conflict, job-caregiving conflict, economic problems and the constriction of social life. Second, there are intrapsychic strains that involve dimensions of self-concept and kindred psychological states. Caregiving can change a person's self-concepts. For instance, past research reported self-concepts may be damaged under persistent hardships, and people under this situation are more likely to suffer symptoms of depression (Pearlin et al., 1981).

Other secondary intrapsychic strains are labeled as situational. There are four types of secondary intrapsychic strains. First, role captivity is an intrapsychic strain that involves being an involuntary incumbent of a caregiver role. When this occurs, the caregiver can experience the sense of being a captive. Another situational secondary intrapsychic strain is the loss of self, which can occur if the identity of the caregiver has been closely bound to the life of the patient. Under this circumstance, the caregiver may experience a loss of his/her own identity as the patient deteriorates. In contrast, two additional intrapsychic strains are competence and gain. Competence refers to the adequacy of performance as a caregiver, and gain and enrichment refers to a sense of personal gain or enrichment from performing the caregiving role. If the caregiver is



unable to experience the sense of competence and gain, she/he may go through a secondary intrapsychic strain.

These two additional aspects of intrapsychic strain are the only positive aspects of the caregiving experience presented in the stress process model. According to the previous caregiving studies, many people report that they experience some inner growth or satisfaction as they manage to provide care for their relatives (Chenoweth & Spencer, 1986; Kinney & Stephens, 1988; Miller & Lawton, 1997; Murphy, 1990; Lawton et al., 1991). One positive aspect of the caregiving experience is that the greater the strength of caregiving satisfaction, the more vulnerable the person is to psychological stress in caregiving commitment. Cantor (1983) noted that those family members who are closest to the frail elderly experienced the greatest amount of strain. However, typical concepts in the caregiving stress framework do not adequately describe positive aspects of the caregiving process (Miller, 1989).

#### Moderators

The next conceptual domain of Pearlin's stress process model is moderators. Pearlin et al. (1981, 1990) suggested that people who typically confront seemingly similar stressors can respond in different ways. Moderators seem to take an important role in providing the explanation for the variability in this outcome. Moderators consist of the social, personal, and material resources that assist in modifying the magnitude of association between stressors and outcomes (Aneshensel et al., 1995; Pearlin et al., 1990; 1981). For instance, the moderators alter the basic stressor and outcomes relationship, intensifying the impact of stress when resources are scarce and reducing it when resources are plenty. These different stress outcomes in caregiving research can be

explained since stress research may underestimate the power of the moderators.

Moderators are the main concept that make Pearlin's stress process model different from other stress models.

Moderators are defined as those behaviors or elements that people can invoke in behalf of their own defense. Pearlin et al. (1981, 1990) suggest the two most important moderators be coping and social support. Coping has three possible functional aspects: management of the situation giving rise to stress, management of the meaning of the situation such that its threat is reduced; and management of the stress symptoms that result from the situation (Pearlin et al., 1990). First, management of the situation includes active behaviors, which aid in coping such as doing only important duties and being firm. The second one is that management of meaning that includes a reduction in expectations, making positive comparisons, and construction of a larger sense of illness. The last one is management of the stress, which includes such things as eating and drinking appropriately, not smoking, and exercise (Pearlin et al., 1990).

Social support is one of the areas in which there is a lack of uniformity of concept, even though many scholars have attempted to bring some clarity to the issue (House, 1981; Pearlin et al., 1989). This lack of consistency has led to contradictory findings concerning the relationship between social support and stress. For instance, some studies find social support modifies the impact of stress outcomes (Dunker-Schetter & Bennett, 1990; Pearlin et al., 1990; Thompson et al., 1993; Zarit et al., 1985), other studies suggest there is no clear understanding of the conditions that determine whether or not support is effective (Clipp & George, 1990; Strawbridge & Wallhagen, 1991; Thompson et al., 1993; Youn et al., 1999). Pearlin et al.(1990) divided social support

into mainly two types of support, instrumental support and expressive support.

Instrumental support defines the availability of a person who assists the caregiver and expressive support indicates the perceived availability of the person who cares for the caregiver.

Coping and social support are distinct; however, they have similar functions in the stress process. They both regulate the effects of stressful conditions. People tend to use both coping and social supports. The moderators can intervene prior to a stressful event, between an event and the life strains, between the strain and the damage to the self-concept, and prior to the stress outcomes (Pearlin et al., 1981).

#### Stress Outcomes

The final conceptual domain of Pearlin's stress process model (Pearlin et al., 1981, 1982, 1985, 1990) is stress outcome. This refers to the consequences of stressors, and involves the level of the well-being of people, their physical and mental health, and their ability to maintain themselves in their social life. For instance, on the mental health aspect, stress outcomes usually include standard symptom measures of depression, anxiety, irascibility, and cognitive disruptions (Pearlin et al., 1990). Several researchers have written about the outcomes of caregiving under the aspect of caregiving burden/strain (Dura et al., 1990, 1991; Haley et al., 1995; Killeen, 1990). However, these numerous studies show the lack of a conceptual uniformity and often suggest contradictory findings.

#### Research Model

On the basis of Pearlin's and associates (1980; 1991) stress process model, this study will focus on the one additional variable at the background and context of the stress

process with other demographic variables (see Figure 2). As explained above, background and context includes the key characteristics of the caregiver, which could impact the caregiving outcome. For this study, the research model also includes one cultural factor, filial obligation. Filial obligation/responsibility is chosen since this variable is strongly related to the cultural values, attitudes, and social orders of Korean caregiving daughters-in-law. Filial obligation/responsibility becomes the background and context variable in this research model.

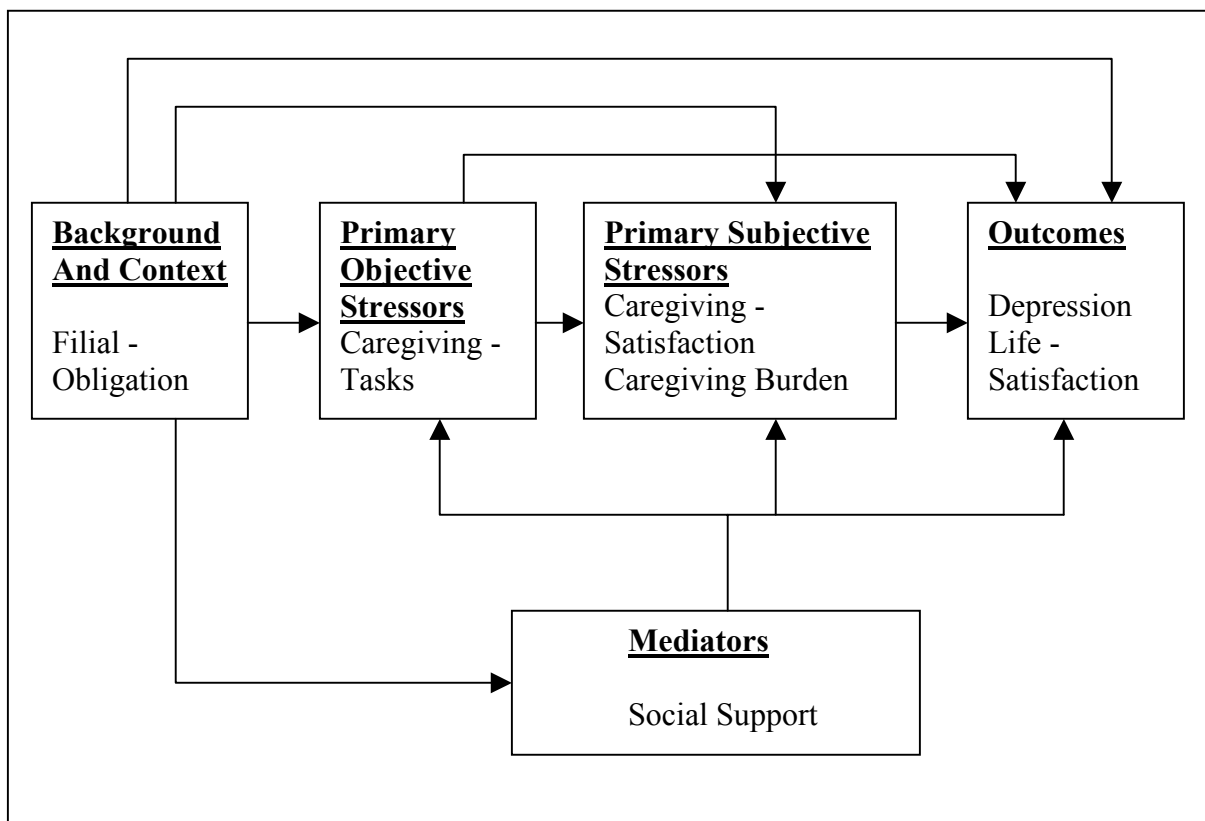


Figure 2. The Research Model

The research model also includes the primary and secondary stressors of caring for elderly parents-in-law. Primary objective stressors will be chosen in this model as objective and measurable caregiving tasks of caregivers. Primary subjective stressors will be represented as caregiving strain/burden and caregiving satisfaction.

This model also includes both the mediators and the outcomes of caregiving stress. The mediators will be narrowly defined as a social support variable and the outcomes of caregiving will be the level of depression and the level of life satisfaction.

## CHAPTER 4

### METHODS

A central focus in this research is defining the caregiving stress process of Korean daughter-in-laws who do provide care for their elderly parents. Another focus is to examine to what extent a cultural factor, filial obligation, is related to the caregiving experiences of daughters-in-law who provide parental care. The research design, sample, instrumentation, data collection procedures, and statistical procedures utilized to study the caregiving experience of daughter-in-laws are described in this chapter.

#### Research Design

This study used a cross-sectional, correlational design with non-probability sampling. A cross-sectional survey was used to assess the impact of the background and context variable filial obligation on stressor variables, caregiving tasks, caregiving burden and satisfaction, and outcome variables, depression and life satisfaction, with the mediating variable social support. This research design is appropriate for this study since it is exploratory in nature and seeks to describe the relationships among the variables, filial obligation, social support, caregiving satisfaction and burden, and caregiving outcomes.

The dependent variables, caregiving outcome, defined as depression, life satisfaction, caregiving burden, and caregiving satisfaction, were identified in the literature review on the caregiving process (Gallant & Connell, 1998; Himes, 1994; Lawton et al., 1991; Merrill, 1993; Mui & Morrow-Howell, 1993; Ory et al., 1999; Pallett, 1990; Pearlin et al., 1990; Sheehan & Donorfio, 1999; Youn et al., 1999).

The independent variables are the ratings of caregiving tasks, filial obligation, and social support of daughters-in-law who provide care for their parents-in-law. In addition to the above independent variables, the following factors are identified as possible influences on caregiving outcomes: (a) age, (b) education, (c) employment status, (d) marital relationship, (e) family income (Choi, 1993), (f) number of chronic conditions (Choi, 1993; Gallant & Connell, 1998), (g) the relationship between caregiver and care recipient (Choi, 1993; Miller et al., 1991; Stuckey & Smyth, 1997), and (h) health characteristics of the elderly (Choi, 1993; Gallant & Connell, 1998).

### Sampling and Participants

In Korea, there is no single organization or governmental agency, which is designed to provide services for family caregivers. In addition, there is no directory or governmental record that provides a comprehensive listing of the names of those who provide care for elderly parents within the same households. This posed a significant limitation on the range of sampling choice; there was no readily available sampling framework appropriate for this study.

Given these circumstances, random sampling was not feasible. Therefore, a purposive sampling approach was used in this study. However, there was no one single best site that permitted sampling of a representative group of family caregivers. For instance, hospital or nursing home agency samples would include only those family caregivers with seriously impaired elderly parents who need medical attention and those who are financially better-off, excluding those with a lack of financial resources or usual family caregivers with less impaired elderly parents in Korea.

In addition, due to the financial, logistical, and time requirements, this study was limited to a sample of family caregivers in one city, Taegu, South Korea. Four of five districts in Taegu agreed to provide a list of apartment areas within their own districts. The researcher approached the listed apartments complexes residents office and requested their cooperation in providing a list of residents' names, addresses, and/or telephone numbers of caregiving children who live with their elderly parents. Six different apartment areas agreed to participate in the study and all daughters-in-law who provide care for their elderly parents-in-law in six apartments were identified. As the result, the researcher compiled a list of 206 caregivers from six different apartment areas and 22 caregivers by referral of the subjects from the six apartments. In all, 152 caregiving daughters-in-law participated in the study and the overall response rate was 66.7 %.

#### Data Collection

The major data collection method for this study was the survey using a structured questionnaire presented in the Appendices. The mailed questionnaire was self-administered. The mailed survey was used in this study because it was more advantageous than telephone or face-to-face interview survey in dealing effectively with sensitive issues.

Residents in the selected apartment areas are recommended to meet monthly. The investigator attended each of the meetings, explained the research, and distributed the questionnaires with the stamped return envelopes. Questionnaires were mailed to those residents who were not in attendance. Twenty-two additional families caregivers,



who agreed to participate, were also given the questionnaire with stamped return envelopes.

The investigator conducted the survey during the period from June 2001 to July 2001. In order to obtain a higher response rate, a second questionnaire was placed in all mailboxes two weeks after first questionnaire was sent out.

### Dependent Variables

The following variables are dependent variables of this study and are defined as follows:

Caregiving outcome – The effects that are usually observed in the caregiving process which involve the well-being of caregivers, their physical and mental health, and their ability to sustain themselves in their social roles (Pearlin et al., 1990). In this study, levels of depression and life satisfaction were utilized to represent the caregiving outcome of daughters-in-law in Korea.

Caregiving satisfaction – It is defined as subjectively perceived gains from desirable aspects of, or positive affective returns from caregiving (Lawton et al., 1991). It is the extent to which the caregiving role is appraised to enhance an individual's life space and to be enriching (Kramer, 1997). It is a specific referent to the caregiving role, psychological well-being that may influenced by, but is potentially independent of, the caregiving experience (Kramer, 1997).

Subjective caregiving burden – It is the perception of psychological distress, anxiety, depression, and loss of freedom attributed directly to caregiving and sometimes refers as the caregiver's subjective response (Montgomery, Gonyea, & Hooyman, 1985).

### Operationalization of Dependent Variables

A 10- page, structured, written questionnaire was developed to collect data from caregiving daughters-in-law. The questionnaire was divided into six sections, and the dependent variables were covered with two sections: the primary subjective stressors as caregiving satisfaction and caregiving burden and caregiving outcome as psychological health and physical health.

Scales in the structured questionnaire to assess the dependent variables were as follows: (a) The Short-Form of The Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977), (b) the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), (c) a self-rated health single-item scale (Haley et al., 1995; Rakowski et al., 1993), (d) Perceived Caregiver Burden Scale (Stommel et al., 1990), and (e) Strawbridge's (1991) Caregiving Satisfaction Scale.

#### Depression

Depressive symptoms were measured with the Iowa Form of the Center for Epidemiologic Studies Depression Scale (CES-D; Kohout, Berkman, Evans, & Cornoni-Huntley, 1993; Radloff, 1997). This Shorter Form of CES-D is an 11-item version of the CES-D, which taps the same underlying dimensions as the original 20-item scale. This scale asks how often respondents experienced each depressive symptom during the past week. Four individual subscales such as depressed mood, positive affect, somatic symptoms, and interpersonal problems are used as separate indicators of the construct. The questions range from 0 = Hardly ever or never to 2 = Much or most of the time. For scoring, items 12, and 16 are reverse-scored, then the scores of all items were summed. This produced a range of 0 to 22, with higher scores indicating greater depression.

The scale has good internal consistency with an alpha of .81, which nearly equals to that of the original version with an alpha of .86. The scale is very easily administered and scored and was found to be easy to use by respondents in both the clinical and general population (Fischer & Corcoran, 1994). This instrument has been used in research on caregiving, stress and coping, and epidemiology of depression (Gallant & Connell, 1998; Haley et al., 1995; Schulz et al., 1990).

### Life Satisfaction

Satisfaction was measured with the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). This scale is designed to assess the individual's own judgment of his or her quality of life and uses a Likert-type response format. The questions range from 1 = Strongly disagree to 7 = Strongly agree. For a total score, each item score was added, with ranges from 5 to 35. A higher score reflects more satisfaction with life.

The 5-item SWLS was selected from a pool of 48 questions based on a factor analysis, and has strong internal consistency and test-retest reliability for a two-month period with an alpha of .87 and a correlation of .82. In addition, it is reported to have good concurrent validity.

### Physical Health

A single-item self-rated 4-point Likert-type question, which asked general health conditions of family caregivers and a question concerning the number of chronic conditions were used to assess health. This combination has been widely used in studies of caregiving (Gallant & Connell, 1998; Haley et al., 1995; Stuckey & Smyth, 1997), with high correlations with physician ratings of health and sensitive to changes in health

over time (Wagner, LaCroix, Grothaus, & Hecht, 1993). This scale ranges from 1= excellent to 4= very poor.

### Caregiving Burden

The Perceived Caregiver Burden Scale (PCB; Stommel et al., 1990) was used to assess perceived caregiver burden. PCB is a 31-item scale developed by systematically identifying the most common stressors named by adult children caring for an elderly parent, and assessed five dimensions of caregiver burden: (1) perceived impact on finances, (2) feelings of abandonment, (3) perceived impact on schedule, (4) perceived impact on health, and (5) sense of entrapment. Each item was rated on a 4-point scale, ranging from 1=strongly disagree to 4=strongly agree. Scores of each item were added, after reverse scoring items 1, 5, 10, 17, and 20, for a total score, with a range from 31 to 124. Higher scores reflect higher levels of caregivers burden.

The Perceived Caregiver Burden Scale by Stommel et al. (1990) has established reliability and validity. The PCB has strong reliability scores. Internal consistency alpha of the PCB is .86, with .72 for “perceived impact on finances”, .87 for “feelings of abandonment”, .81 for “impact on schedule”, .85 for “impact on health”, and .87 for “sense of entrapment” in the U.S. (Stommel et al., 1990). It also has very good construct validity.

The Perceived Caregiver Burden Scale by Stommel et al. (1990) has also been used for assessing the degree and nature of caregiving burden among Koreans (Choi, 1993). Choi (1993) modified the measurement of each dimension of caregiver burden in order to increase the relevance and appropriateness of the scale for Korean caregivers. Therefore, 20 of the 31 original items were kept in the modified scale as a result of a

factor analysis of the scale as a basis for assessing Korean caregiver burden. These items were equal to or larger than .70 in both Varimax and Oblimin rotated factor analysis.

This modified PCB score was the sum of all the responses to the 4-point scale items of the specific dimensions. Thus, the score of “perceived impact on finances” with 3 items ranged 3 to 12, “feelings of abandonment” with 3 items from 3 to 12, “perceived impact on schedule” with 5 items from 5 to 20, “perceived impact on health” with 2 items from 2 to 8, and “sense of entrapment” with 7 items from 7 to 28. The higher score indicated the greater caregiver burden. The reliability coefficients for the modified scale were .92, with .90 for “perceived impact on finances”, .91 for “feelings of abandonment”, .94 for “perceived impact on schedule”, .97 for “perceived impact on health”, and .94 for “sense of entrapment” (Choi, 1993).

#### Caregiving Satisfaction

Caregiving satisfaction was assessed by a 15-item Strawbridge’s Caregiving Satisfaction Scale (1991). This scale was designed to capture more long-term satisfactions and rewards than momentary uplifts like feeling good today because the care recipient smiled. Scoring is with a 4- point Likert-type response from 1=strongly agree to 4= strongly disagree. Higher scores indicate a higher level of satisfaction with caregiving. The scale has a strong internal consistency with an alpha of .90. This instrument has been used in research on caregiving studies (Strawbridge, 1991; Kramer, 1993a; Kramer, 1993b).

## Independent Variables

The following concepts are the independent variables of this study.

Caregiving task – It is amount of the actual involvement of the caregiver in caregiving (Strawbridge, 1991).

Filial obligation – It is defined as caring for a parent or in-law out of a sense of family obligation (Strawbridge, 1991).

Social support – It is emotional and validating support including the tangible assistance provided by others (Stuckey, & Smyth, 1997).

Caregiving daughters-in-law – They are daughters-in-law who provide care for elderly parents in same household.

Elderly parents – They are people over 60 years old who live with their adult children in the same household.

## Operationalization of Independent Variables

Scales in the structured questionnaire used to assess the independent variables were as follows: (a) Duty Scale (Strawbridge, 1991) adapted from Seelbach and Sauer's Duty Scale (1977), (b) Caregiving Tasks Scale (Strawbridge, 1991) adapted from Stetz (1986) and Wallhagen (1990), (c) The Interpersonal Support Evaluation List (ISEL: Cohen & Hoberman, 1983).

### Filial Obligation

Filial obligation was measured with a 13- item scale modified by Strawbridge (1991). This scale was originally from Seelbach and Sauer (1977). Among the 13 items, four of the items were adapted from Seelbach et al. (1977) and nine items were added by Strawbridge (1991). This 13-item scale was intended to measure obligatory feelings of

caring for the care-recipient over a wide range of activities (Seelbach et al., 1977; Strawbridge, 1991). Eleven items involved specific feelings about the person being cared for, such as “ Because (care-recipient) is my (relationship), I feel I should take care of (him/her) now that (he/she) is old and frail.” For comparison purposes two general questions on the importance of family values and feelings about adult children caring for frail parents were also included. Scoring was with a 4- point Likert-type scale from strongly agree to strongly disagree. The scale has good internal consistency with an alpha of .81 (Strawbridge, 1991).

### Caregiving Tasks

Caregiving tasks were measured with the Stetz Inventory, Part I (Stetz, 1986) as modified by Wallhagen (1990). This scale includes 15 specific questions about caregiving activities which are simply coded responses “yes” or “no” from Stetz (1986). Wallhagen (1990) modified this scale response to a six-item frequency range from “never”, “ rarely”, “several times a month”, “everyweek”, “several times a week” to “daily” to obtain more varied response. The reliabilities reported for the scale were an alpha coefficient of .85 and .86. Higher scores indicate more extensive involvement with caregiving tasks.

### Social Support

The perceived availability of potential social support resources was assessed with The Interpersonal Support Evaluation List (ISEL: Cohen & Hoberman, 1983). The ISEL is a 40-item, self-reported instrument designed to assess perceived social support with four different types of social support, which are tangible support, emotional support, self-esteem support, and belonging support. This scale has four subscales and has been

studied with a variety of diverse samples (Fisher & Corcoran, 1994). Questions are in a true/false format, and each subscale is comprised of 10 items, five positive and five negative statements. Scales are summed by counting the number of responses indicating support and divided by the number of items for a total score. Subscales are scored in the same manner. Higher scores indicate higher perceived support.

The ISEL has very good internal consistency with alpha of .81 for the total scale and .72 to .84 for the subscales. Correlation for test-retest reliability for a six-month period is .74. In addition, this scale has good factorial validity, good construct validity, and good concurrent validity, showing a negative correlation with depression and a positive correlation with well-being (Fisher & Corcoran, 1994).

The ISEL by Cohen et al. (1983) has also been used for assessing the degree and nature of social support among Korean immigrants in the U.S. (Choi, 1997). The ISEL has very good internal consistency with Cronbach's alpha of .91 for Korean immigrants. The reliability coefficients for the subscales scale were .78 for emotional support, .75 for belonging support, .83 for tangible support, and .76 for self-esteem support (Choi, 1997).

#### Sociodemographic Information

Caregiving daughter-in-law was operationalized as the one who identified herself as the family member who was primarily responsible for the elderly parents care. Elderly parents were operationalized as those who over 65 years old who live with their adult children in the same household.

Age was assessed with two different questions, current age and date of birth. Employment status included full-time, part-time, retired or unemployed, and homemaker.



Marital status was categorized as married, divorced or separated, widowed, or single. The number and make up of the household were assessed. The respondents were asked their educational level, elementary, middle, high school, college, or graduate school. Income level for the household was ascertained by asking the respondents to rank their income level as high, middle-high, middle, middle-low, or low. Culturally, Koreans consider it rude to ask specific questions about their income and are reluctant to answer them.

### Intervening Variables

In addition to the above dependent variables, earlier research findings on the caregiving process indicate several intervening variables. Intervening variables identified in previous research are length of caregiving time, number of caregivers' chronic conditions, the relationship between caregivers and care recipients, and quality of the relationship between caregivers and their spouse (Choi, 1993; Miller et al., 1991). In addition, the number of care recipient's physical and/or cognitive impairments was included (Choi, 1993; Miller et al., 1991; Youn et al., 1999). These questions are designed to help assess the influence of the above intervening variables on the caregiving process.

### Other Open-Ended Questions

Other open-ended questions included describing how caregivers came to be the primary caregivers for their parents-in-law and whether other siblings or relatives support/help them or pressure them regarding providing care for the elderly. Furthermore, major problems or difficulties in caring for the elderly and main motives for them providing care for their parents-in-law in the same households were asked to find out how much support or pressure these caregivers felt.

### Translation of Instruments

Some instruments in this study were translated into Korean by the investigator and some were already used for Koreans. The instruments assessing caregiving burden and social support were already available in Korean, and the instruments regarding filial obligation, caregiving satisfaction, life satisfaction, depression, and caregiving tasks were translated by the investigator. The instruments translation was more focused on its underlying meaning rather than a literal word-by-word manner.

Based on the translation procedure suggested by Brislin (1976), after the instruments were translated into Korean, they were translated back to English by a second translator. A third person compared the original English version with the back-translated English version of the instruments. When ambiguity was found, the translators checked both the Korean version and the back-translated version to resolve the discrepancy by finding the source of the error and by going through the translation procedure for those items.

### Data Analysis and Statistical Procedures

Several statistical procedures were used to analyze data. In order to describe the data generated from the study, descriptive statistics, such as frequency distribution, central tendency and dispersion, were used.

Some measurement scales only developed and tested in the U.S, such as Caregiving Satisfaction Scale, Caregiving Tasks, Filial Obligation, Depression, and Life Satisfaction, may present some limitations in applying them in another country with a different culture. Therefore, reliability tests were conducted on such scales in order to assess internal consistency with a Korean sample.

Multiple linear regression analysis was employed to test the following hypothesis addressed in this study: The stress process model, which includes filial obligation, would better predict caregiving primary subjective stressors (caregiving burden and caregiving satisfaction) and caregiving outcomes (life satisfaction and depression). Multiple regression analysis was employed to evaluate two regression equations with and without the filial obligation variable, so one can statistically assess which model better accounts for the greatest proportion of variance in caregiving daughters-in-law's ratings on caregiving primary subjective stressors and caregiving outcomes. Specifically, the coefficient of determination ( $R^2$ ), standardized regression coefficient ( $\beta$ ), and its statistical significance ( $p$ ) were utilized and each hypothesis was tested at the  $p < .05$  level.

A partial correlation coefficient was employed to test the following hypotheses: First, the background and context variable (filial obligation) is positively related to the primary objective stressor (caregiving tasks), and the primary subjective stressor (caregiving satisfaction) is mediated by social support, while it is negatively related to the other primary subjective stressor (caregiving burden). Next, filial obligation is positively related to caregiving outcome (life satisfaction), yet, negatively related to caregiving outcome (depression) as mediated by social support. The last, there are the relationships between the primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (depression and life satisfaction) as mediated by social support.

Pearson's correlation coefficient analysis was also used to examine relationships between social support, which was controlled in the hypotheses testing, and other identified variables in the stress process model. In addition, this analysis was used

to examine the relationships between other demographic variables (such as age, education, and so on) and the identified variables in the stress process model.

Finally, a step-wise multiple regression analysis was employed to assess other intervening variables, which were not included in the research hypotheses, to predict caregiving outcomes (life satisfaction and depression).

## CHAPTER 5

### FINDINGS

The findings of the study will be presented in four sections. The first section describes the characteristics of family caregiving practice for elderly parents in Korea. The second section consists of findings on the scales used for data collection in the study. The third section presents the effects of filial obligation and other intervening variables on the caregiving process in Korea. The last section describes the responses of the open-ended questions regarding the caregiving process.

#### Sample Characteristics

The average age of the caregivers was 41.34 (SD = 9.76 years) and the range was 25-62 years of age. As Table 1 shows, 44 % (n =67) of the caregivers belonged to the age category of 30-39 years. These caregivers were likely to have other obligations which compete with caregiving roles. Older caregivers aged 50 or over made up 23.7% (n =36) of all the caregivers in the study.

The majority (n =148; 97.4%) of the caregivers in this study were married, 2.6% (n = 4) were widowed, and no one was divorced or separated, an understandable distribution as the study is daughters-in-law who provide care for their parents-in-law. As discussed in the preceding chapter, Korean cultural norms expect daughters-in-law to provide care for their parents-in-law, so each caregiver was connected through a marriage contract. Over 30 % of the respondents (n = 64) were married less than 10 years, and one fourth of the respondents (n=41) were married between 10 and 20 years. As summarized in Table 1, the average length of marriage in the sample was 14 years 9 months.

Table 1  
Personal Characteristics of Caregivers

	<u>n</u>	%
Caregivers' Age ( N = 152 )*		
<30	15	9.9
30 – 39	67	44.0
40 – 49	34	22.4
50 – 59	29	19.1
>=60	7	4.6
Marital Status ( N =152 )		
Married	148	97.4
Divorced	0	0
Widowed	4	2.6
Separated	0	0
Length of Marriage ( N = 152 )**		
< 9.9 years	64	42.1
10 – 19.9	41	27
20 – 29.9	29	19.1
>=30	18	11.8
Caregivers' Education Level ( N = 152 )		
Elementary	5	3.3
Junior high school	10	6.6
High school	49	32.3
College	85	55.9
Graduate school	3	2

Note. \* Mean = 41.34, SD = 9.76, Range = 25-62.

\*\* Mean = 14.9, SD =10.46, Range = .3 – 40.6

The educational levels of most of the caregivers were relatively high. More than half of the caregivers (55.9%; n = 85) finished college, 32.2 % (n = 49) indicated

high school as their highest level of formal education, 6.6 % (n = 10) were junior high school graduates, 3.3% (n = 5) were elementary school graduates, and an equally small percentage (2%; n = 3) finished graduate school.

Table 2 summarizes the number of family members in the household, the number of children, family income levels, and caregivers' job status. The number of family members in the household ranged from 3 to 8, with an average number of 4.69 (SD = 1.00). However, over half of the caregivers (61.8%, n = 94) indicated having 5 - 6 family members in their households. The number of children ranged from 0 to 5, with an average number of 1.95 (SD = .99). Almost two thirds (74.3%; n =110) of the caregivers indicated having 1-2 children, 20.3 % (n =30) indicated having 3-5 children, and only 5.4% (n =8) had no children.

Originally, the level of family income was asked numerically. However, upon a Korean professor's recommendation, the level of family income was questioned with ranks (high, middle-high, middle, middle-low, and low) out of respect for Korean culture and morale. Asking the exact numbers of one's income is considered rude, and most people are unwilling to disclose their income with numbers in Korea. Almost two thirds (69.1%; n =105) of the caregivers indicated as middle class, 15.1% (n =23) mentioned as middle- high class, 13.8% (n = 21) indicated as middle-low class, 1.3 % (n =2) were low class, and .7% ( n =1) were high class.

More than half of the respondents (54.6%, n = 83) were employed. Almost one third of the caregivers (32.2%, n = 49) were homemakers, 41.4 % ( n = 63) had full-time jobs, 5.3% (n=8) had part-time jobs, 7.9% (n =12) were self-employed, 12.5% (n = 19) held other types of jobs which included volunteer, religious jobs such as teaching the

bible and cleaning the churches, and helping the family business without a salary, and only one person (.7%) was retired.

Table 2

## Personal Characteristics of Caregivers

	<u>n</u>	%
Number of family members ( N = 152 )*		
3 – 4	55	36.2
5	70	46.1
6	24	15.8
7 – 8	3	2.0
Number of Children ( N = 152 )**		
0	8	5.4
1 – 2	110	74.3
3 – 5	30	20.3
Ranks of family income level ( N = 152 )		
High (Over \$ 100, 000)	1	.7
Middle- high ( \$ 75,000 – 99,000)	23	15.1
Middle ( \$ 50,000 –74,000)	105	69.1
Middle-low ( \$ 21,000 –49,000)	21	13.8
Low (Under \$ 20,000)	2	1.3
Caregivers' job status ( N = 152 )		
Full-time	63	41.4
Part-time	8	5.3
Self-employed	12	7.9
Homemaker	49	32.2
Retired	1	.7
Others	19	12.5

Note. \* Mean = 4.69, SD = 1.00, Range = 3-8

\*\* Mean = 1.95, SD = .99, Range = 0-5



The average length of time providing care for parents-in-law was 10 years and 10 months (SD = 9.25). The range of the length of providing care for parents-in-law for this sample was from 3 months to 40 years and 5 months. More than half of the respondents (59.2%) provided care for one to 10 years (n = 90), 19.8 % for 10 to 20 years (n = 30), 15.1 % for 20 to 30 years (n = 23), 3.3% for over 30 years (n = 5), and 2.6 % (n = 4) less than 1 year.

Table 3 summarizes the number of caregivers' chronic diseases, and caregivers' physical conditions. Less than one fourth of the caregivers (n = 33, 21.7%) had a chronic physical disease. Among them, 29 (87.9%) caregivers had one or two chronic diseases and 4 (12.1%) caregivers had 3 to 5 chronic diseases. A single-item self-rated 4-point Likert-type question was used to assess health. The mean score (1.68) on the question indicated that overall, the caregivers rated their physical condition as good. Over one-third of the caregivers (n = 61, 40.1%) indicated their physical condition as excellent, 52% (n = 79) of the caregivers as good physical condition, 12 caregivers (7.9%) as poor physical condition, and nobody indicated they were in very poor health.

On average, the respondents (m= 2.35; SD =.96) felt that the quality of the relationship with their parents-in-law was good. Almost 20% (n =30) of the caregivers felt they had a very good relationship with their parents-in-law, 35.5% (n =54) had a good relationship, 35.5% (n =54) had a fair relationship, 7.9% (n =12) respondents had a bad relationship, and only 1.3% (n = 2) had a very bad relationship with their care-receivers.

Table 3  
 Characteristics of Caregiving Practice

	<u>n</u>	%
Chronic physical disease of caregivers (N = 152)		
No	119	78.3
Yes	33	27.1
Number of disease of caregivers ( N = 33)		
1 – 2	29	87.9
3 – 5	4	12.1
Caregivers' physical condition ( N = 152 )		
Excellent	61	40.1
Good	79	52.0
Poor	12	7.9
Very poor	0	0

As shown in Table 4, almost half (49.7%; n = 75) of the caregivers had good relationships with their husbands. The mean score (  $m = 3.80$ ;  $SD = 1.78$ ) also indicates that on average, the respondents felt their relationship with husbands was good. Thirty caregivers (19.9%) responded that they had very good relationships with their husbands, thirty-two (21.2%) had a fair relationship, and fourteen caregivers (9.2%) felt they had a bad relationship with their husbands. Caregiving did not appear to have a major impact on the marital relationship.

Furthermore, the mean score (3.92;  $SD = 1.74$ ; n = 141) on the caregivers' quality of relationship scale indicated that overall caregivers felt their relationship with children was good. Less than half of the caregivers (n = 65, 46.1%) felt their relationship with children was good, 37 caregivers (26.2%) felt the relationship was very good, 30

(21.3%) felt it was fair, and 9 (6.4%) respondents reported bad relationships with their children. Overall, respondents seemed to have a good relationship with their children, in spite of providing care for their parents-in-law.

Table 4

## Caregivers' Quality of Relationships

	<u>n</u>	%
Relationships with care-receivers ( N =152 )*		
Very good	30	19.7
Good	54	35.5
Fair	54	35.5
Bad	12	7.9
Very bad		2
1.3		
Relationship with husband ( N = 151 )**		
Very good	30	19.9
Good	75	49.7
Fair	32	21.2
Bad	14	9.2
Very bad	0	0
Relationship with children ( N = 141 )***		
Very good	37	26.2
Good	65	46.1
Fair	30	21.3
Bad	9	6.4
Very bad	0	0
Note. * Mean = 2.35	SD = .96	Range = 1 – 5
** Mean = 3.80	SD = 1.78	Range = 2 – 5
*** Mean = 3.92	SD = 1.74	Range = 2 – 5

Table 5 summarizes not only the age of the parents-in-law and but also the health condition of the parents-in-law. Over half of the caregivers (54.6%;  $n = 83$ ) provided care for only their mother-in-laws, eighteen caregivers (11.8%) provided care for only their father-in-laws, and 33.6% ( $n = 51$ ) provided care for both parents-in-law.

The mean age of the father-in-laws were 69.32 ( $SD = 8.28$ ;  $n = 68$ ) with a range of 52 to 89 years of age. There were 28 (41%) of the fathers-in-law between 60 and 69 years old, 38.2% ( $n = 26$ ) were between 70 and 79, seven (10.3%) were between 50 and 59, and seven (10.3%) were over 80 years old.

Furthermore, the mean age of mothers-in-law was 69.80 ( $SD = 9.32$ ;  $n = 131$ ) with a range of 50 to 90 years of age. Over one third (35.2%;  $n = 46$ ) of the mothers-in-law were between 60 to 69 years old and 45 (34.3%) mothers –in-law were between 70 to 79 years old. Twenty-two (16.8%) were over 80 years old and only eighteen (13.7%) were between 50 to 59 years old.

As shown in the Table 5, over half of the parents-in-law ( $n = 79$ ) had physical and/or cognitive impairment and 48% ( $n = 73$ ) of the elderly parents-in-law had no impairment. Among them, 58 elderly (73.4%) had physical impairments, 6 elderly (7.6%) had cognitive or mental impairments, and 15 elderly (19%) had both physical and cognitive or mental impairments.

According to the elders' medical diagnosis, 26 elders (22%) had arthritis, 21 (17.8%) for high blood pressure, and 18 elders (15.3%) had diabetics. In addition, as shown in Table 5, the elderly in –laws in the study experienced many different kinds of diseases, such as back problems, stroke, dementia, and so on.

Table 5

## Characteristics of the Elder

	<u>n</u>	%
Caregivers' relationship to elder ( N = 152 )		
Father-in-law	18	11.8
Mother-in-law	83	54.6
Both parents-in-law	51	33.6
Age of father-in-law (N =68)*		
50 – 59	7	10.3
60 – 69	28	41.2
70 – 79	26	38.2
80 – 89	7	10.3
Age of mother-in-law (N =131)**		
50 – 59	18	13.7
60 – 69	46	35.2
70 – 79	45	34.3
80 and over	22	16.8
Elders' diseases ( N = 152 )		
No	73	48
Yes	75	52
Kind of impairment (N = 79)		
Physical	58	73.4
Cognitive or mental	6	7.6
Both physical and cognitive	15	19.0
Medical diagnosis ( N= 79)		
Arthritis	26	22.0
Alcoholic		2.5
Dementia	11	9.3
Diabetic	18	15.3
Back pain	6	5.1
High Blood Pressure	21	17.8
Stroke	13	11.0
Heart disease	10	8.5
Leg pain	4	3.4
Eye	3	2.5

Note \* Mean = 69.32      SD = 8.28      Range = 52 – 89

\*\* Mean = 69.80      SD = 9.32      Range = 50 – 90

## Findings on Measurement Scales

In order to assess the reliability of each measurement instrument utilized in the study, the alpha coefficient was used. Psychometric properties of the scales employed in the study are presented in Table 6. The procedures for scale modification and application involved checking items, which had low item-to-total correlations (less than .20) and negative inter-item correlations with other items. Only the scale of filial obligation met the above criteria, which had low item-to-total correlations and negative inter-item correlations with other items, which will be documented later.

### Life Satisfaction

This 5- item Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) achieved an alpha coefficient of .86 in this study. This scale assesses the respondent's judgment of his or her quality of life. The mean of 19.76 in this sample indicated that the respondents were neither satisfied nor depressed. The mean score in this study was lower compared to previous studies, which reported means of 23.5 for undergraduate students and 25.8 for elderly citizens. Scores in this sample ranged from a low of 5 to a high of 34; the lowest possible score would have been 5 for someone who is never satisfied with all 5 items and the highest, 35 for someone who is satisfied with all 5 items all the time.

### Caregiving Tasks

Caregiving Tasks Scale modified by Wallhagen (1988) contains 15 items and the reliability of the scale for this sample was an alpha coefficient of .90. The mean score on the scale was 44.52 indicating that the respondents provided care to their parents-in-law almost every week on average. Scores ranged from a low of 20 to a high of 89. The

lowest score would be 15 for someone who never provided care and the highest would be 90 for someone who provided care all the time. The minimum score of 20 indicates that the respondents provided at least certain minimum levels of care for their elderly parents-in-law. Respondents needed to provide a minimum of care in order to participate in the study, so it would be unlikely that anyone would score lower than 20.

### Filial Obligation

Filial obligation was the only scale where one item had item-to-total correlations of less than .20 and was negatively correlated with more than three of the other items. This item dealt with feelings that caregivers with family or job responsibilities should not be expected to provide care for their aging parents-in-law. Given the Korean cultural and traditional background and the reality that most married women have family or job responsibilities, many respondents seem to consider this item to be inappropriate and had difficulty answering it. Even though this one item showed a low and negative correlation with other items, the original 13-item scale was used, because there was almost no difference in the Cronbach's alpha after dropping it. Therefore, the decision was made to maintain the integrity of the scale.

The 13-item scale had an alpha coefficient of .79, a mean of 27.31, and a range of 14 to 37. With a possible range of 13 to 52, the mean score in the current study indicated that caregivers were neutral with respect to feelings of obligation about caring for their parents-in-law.

### Caregiving Satisfaction

The 15-item Caregiving Satisfaction scale had an alpha coefficient of .85 in this study. The mean score of the scale was 35, which was lower than a mean of 43.9 for

elderly caregivers in the U.S. The range of the scale was 18 to 52. Possible range for this scale is 15 to 60. The scores in the study indicate that the respondents, on the average, found satisfaction in providing care for their parents-in-law.

### Caregiving Burden

The 20-item Perceived Caregiver Burden Scale (PCB; Stommel et al., 1990) was used to assess the perceived caregiver burden. The scale achieved an alpha coefficient of .84, a mean of 53.09, and a range of 35 to 74. Higher scores reflect caregiver's higher levels of burden.

The mean of this scale was somewhat above the theoretical mean ( $m = 40$ ), and it would indicate the respondents generally perceived providing care for their parents-in-law as burdensome. The possible range of scores on this scale is 20 to 80 and actual scores ranged across the entire scale, indicating that respondents' perception of caregiving burden varied greatly.

### Social Support

Social support resource was measured with The Interpersonal Support Evaluation List (ISEL; Cohen & Hoberman, 1983). Questions are in a true/false format and total scores are summed by counting the number of responses indicating support. Higher scores indicate higher perceived support. The alpha coefficient was .86 in this study. The mean score of this scale was 31.74, the standard deviation of 5.63, and the range of 11 to 39. The mean score of this scale indicates that on the average, the respondents would have some level of social resources including tangible support, appraisal support, self-esteem support, and belonging support.



### Depression

The 11-item Iowa Form of CES-D (CES-D; Kohout, Berkman, Evans, & Cornoni-Huntley, 1993; Radloff, 1997) was utilized to measure depressive symptoms such as depressed mood, positive affect, somatic symptoms, and interpersonal problems. The scale had an alpha coefficient of .77, a mean of 6.55, and a range of 0 to 15. The theoretical range of the scale is 0 to 22, and higher scores reflect greater depression. The mean score of the scale (6.55) indicates that these caregivers generally feel only minimal levels of depression.

Table 6

#### Descriptive Statistics for Scales in the Research Model

Scale	Mean	SD	Alpha	Prev. Alpha
Life Satisfaction	19.76	5.49	.86	.87
Caregiving Tasks	44.52	14.74	.90	.86
Filial Obligation	24.94	4.87	.79	.81
Caregiving Satisfaction	35	6.18	.85	.90
Caregiver Burden	53.09	6.45	.84	.92
Social Support	31.74	5.65	.86	.91
Depression	6.55	3.44	.77	.81

### Hypotheses Testing

This research proposed to test the hypotheses which includes filial obligation, a background and context variable, in the caregiving process. First, the proposed conceptual model, which included filial obligation, is tested by using a multiple

regression analysis. Next, the effects of filial obligation on the caregiving process were examined by employing a partial correlation analysis and the relationship between variables in the caregiving process was examined by using a Pearson's correlation analysis

The research utilized an exploratory cross-sectional survey design. The first hypothesis proposed that the stress process model, which includes filial obligation as the background and context variable, will better predict caregiving primary subjective stressors (caregiving burden and caregiving satisfaction) and caregiving outcomes (life satisfaction and depression). The full model for primary subjective stressors (caregiving satisfaction and caregiving burden) includes filial obligation, caregiving tasks, and social support, while the reduced model is the full model without filial obligation. The full model for the caregiving outcome variables (life satisfaction and depression) includes caregiving tasks, social support, caregiving burden, caregiving satisfaction, and filial obligation, while the reduced model is the full model without filial obligation. Multiple linear regression analyses were run using both models to test the hypothesis. The findings are presented in Table 7.

The multiple regression analyses for primary subjective stressors (caregiving satisfaction and burden) were statistically significant at the  $p < .001$  with the distinctive increase of  $R^2$  in each case with the inclusion of the background and context variable, filial obligation (see Table 7). These findings do support the research hypothesis that filial obligation is an important component which helps to explain the variation of caregiving satisfaction and caregiving burden.

In addition, the multiple regression analyses for caregiving outcomes (life satisfaction and depression) indicated that the  $R^2$  did increase a little with the inclusion of filial obligation, the background and context variables, with statistical significance at the level of  $p < .001$ . As shown in Table 7, however, including filial obligation resulted in almost no difference in predicting the variance in depression and life satisfaction, so filial obligation accounted for a very small difference in caregiving outcomes (life satisfaction and depression). These results do not support the research hypothesis that filial obligation is an important aspect in the caregiving stress process.

Table 7

## Comparison of Reduced and Full Models

Outcome Measure	Full Model	$R^2$	Reduced Model
Life Satisfaction	.244 **		.235**
Depression	.314**		.312 **
Caregiving Satisfaction	.320**		.106 **
Caregiving Burden	.302**		.145 **

\*\* $p < .001$

Even though there were almost no differences in the  $R^2$  in caregiving outcome measures (life satisfaction and depression), the results of the final regression equation of caregiving outcomes were statistically significant. Table 8 summarizes the results from final regression equations with the caregiving outcome measures. Interestingly, caregiving satisfaction is the strongest statistically significant contributor in explaining

the variance in life satisfaction ( $\beta = .293, p < .001$ ), and four other variables (filial obligation, caregiving tasks, social support, and caregiving burden) with caregiving satisfaction together explains 24% of the variance in life satisfaction ( $R^2 = .244, p < .001$ ). The final regression for depression also suggests that social support ( $\beta = -.415, p < .001$ ) and caregiving burden ( $\beta = .281, p < .001$ ) are two strong contributors in explaining the variance in depression and all five variables together explains 31% of the variance in depression ( $R^2 = .314, p < .001$ ).

Table 8

Results from Final Regression Equation with Caregiving Outcomes and The Primary Subjective Stressors

Outcome Measures	Variables	B	SE B	$\beta$
Life Satisfaction	Caregiving Satisfaction	-.261	.077	.293**
Depression	Social Support	-.254	.046	-.415**
	Caregiving Burden	-.150	.044	.281**
Caregiving Satisfaction	Filial Obligation	.616	.089	.489**
Caregiving Burden	Filial Obligation	-.553	.094	-.417**
	Social Support	.341	.081	.297**

Note.  $R^2 = .244$  for life satisfaction ( $p < .001$ );  $R^2 = .314$  for depression ( $p < .001$ ),

\*\* $p < .001$ .

The second hypothesis tested the relationships between the background and context variable (filial obligation) and primary objective stressors (caregiving tasks), and primary subjective stressors (caregiving satisfaction and caregiving burden) as mediated by social support. Specifically, positive relationships are hypothesized between filial obligation and caregiving tasks and between filial obligation and caregiving satisfaction when controlling for the mediating variable, social support. In addition, a negative relationship is hypothesized between filial obligation and caregiving burden when controlling for the mediating variable, social support. Table 9 summarizes the results of the hypothesis tests, using partial correlation coefficients based on the theoretical model shown in Chapter 3.

The partial correlation coefficients indicate that after controlling for caregivers' level of social support, caregivers with a high level of filial obligation were likely to experience higher levels of caregiving satisfaction ( $r_p = .52, p < .001$ ) and lower levels of caregiving burden ( $r_p = -.43, p < .001$ ). In addition, the relationship between filial obligation and caregiving tasks was a very small positive one ( $r_p = .20, p < .05$ ) when controlling for social support; however, the relationship was statistically significant. Therefore, the results suggest that there is little relationship between filial obligation and the primary objective stressor when the effects of social support are controlled.

The third hypothesis tested relationships between the background and context variable, filial obligation and caregiving outcomes (life satisfaction and depression) when controlling for the mediator variable, social support. Specifically, the relationship between filial obligation and life satisfaction when controlling for social support is hypothesized as a positive one, while the relationship between filial obligation and

depression is a negative one. Table 9 also summarizes the relationships between filial obligation and caregiving outcomes (life satisfaction and depression) when controlling for social support.

There was a statistically significant relationship between filial obligation and life satisfaction when controlling for social support ( $r_p = .37$ ,  $p < .001$ ), which indicates that caregivers with higher levels of filial obligation seem to experience higher levels of life satisfaction regardless the levels of social support. However, there was no statistically significant relationship between filial obligation and depression when controlling for social support. Therefore, caregivers' levels of filial obligation are not associated with levels of depression when the effects of social support are controlled.

Table 9

Partial Correlation Coefficients between Filial Obligation and Primary Objective Stressor, Primary Subjective Stressors, and Caregiving Outcomes When Controlling for Social Support

Filial Obligation	$r_p$
Caregiving Tasks	.196 *
Caregiving Satisfaction	.521**
Caregiving Burden	-.429**
Life Satisfaction	.370**
Depression	-.057

\*\*p < .001, \*p < .01

The last hypothesis examined relationships between primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (life satisfaction and depression) as mediated by social support. Specifically, when controlling for social support, caregiving satisfaction is positively related to life satisfaction, yet negatively related to depression. In addition, when controlling for social support, caregiving burden is positively associated with depression, yet negatively associated with life satisfaction. Table 10 summarizes the findings of the hypothesized relationships.

The findings of the study support the positive relationship between caregiving satisfaction and life satisfaction when controlling for social support ( $r_p = .43, p < .001$ ). It suggests that the greater the level of caregiving satisfaction the caregivers felt, the more life satisfaction caregivers experienced when their social support was held at a constant level. The negative relationship between caregiving burden and life satisfaction ( $r_p = -.27, p < .001$ ) and the positive relationship between caregiving burden and depression ( $r_p = .27, p < .001$ ), when controlling for social support, was also supported by the findings of the study.

Table 10

Partial Correlation Coefficient between Primary Subjective Stressors and Caregiving Outcomes When Controlling for Social Support

	<u>Caregiving Satisfaction</u>	<u>Caregiving Burden</u>
	$r_p$	$r_p$
Life Satisfaction	.429**	-.265**
Depression	-.044	.266**

\*\*p<.001

These findings indicate that the more caregiving burden daughters-in-law experience, the more depression, and the less life satisfaction they have independent of their levels of social support. However, the findings showed no statistically significant relationship between caregiving satisfaction and depression when social support was held at a constant level. Those daughters-in-law who exhibit a high level of caregiving satisfaction were not depressed, regardless of their levels of social support.

Pearson's correlation coefficients were employed to examine the following relationships; between the primary objective stressor (caregiving tasks) and the primary subjective stressors ( caregiving burden and caregiving satisfaction), between the primary objective stressor and caregiving outcomes (life satisfaction and depression), between social support and other identified variables on the caregiving process such as filial obligation, caregiving tasks, caregiving satisfaction, caregiving burden, life satisfaction and depression. Table 11 summarizes these correlation coefficients.

The levels of caregiving tasks showed small, negative relationships with the levels of caregiving satisfaction ( $r = -.25, p < .01$ ) and life satisfaction ( $r = -.18, p < .05$ ). Although the correlations were relatively small, they suggest that caregivers who have more caregiving tasks were likely to report lower levels of caregiving satisfaction and life satisfaction. In addition, the levels of caregiving tasks showed no statistically significant relationship with three other variables, such as social support, caregiving burden, and depression. Therefore, the level of caregiving tasks is negatively related to the levels of positive aspects of caregiving process, while it shows no relationships with negative aspects of caregiving process.



The correlation coefficients between social support and six other variables revealed that the relationships between social support and caregiving burden ( $r = -.40$ ,  $p < .001$ ), and between social support and depression ( $r = -.51$ ,  $p < .001$ ), are stronger than the relationships between social support and life satisfaction ( $r = .22$ ,  $p < .01$ ) and between social support and caregiving satisfaction ( $r = .21$ ,  $p < .01$ ). These findings suggest that caregivers with a higher level of social support were likely to experience lower levels of caregiving burden and depression, while they were likely to report higher levels of caregiving satisfaction and life satisfaction. The findings also imply that the level of social support is more important for the negative aspects of the caregiving process, which are caregiving burden and depression, than the positive aspects of caregiving process, which are caregiving satisfaction and life satisfaction.

Furthermore, significant correlation coefficients were also found between the dependent variables and the independent variables on the caregiving stress process. The correlation coefficients between filial obligation and caregiving satisfaction ( $r = .54$ ,  $p < .001$ ), between filial obligation and life satisfaction ( $r = .40$ ,  $p < .001$ ), between caregiving satisfaction and life satisfaction ( $r = .46$ ,  $p < .001$ ), and between caregiving burden and depression ( $r = .41$ ,  $p < .001$ ) indicated statistically significant, moderately positive relationships. These findings revealed no differences in the level of relationships among the above variables when controlling for social support, so social support was likely to have little impact on the relationships between variables. Additionally, no relationships between variables in the primary subjective stressors (caregiving burden and caregiving satisfaction) and caregiving outcomes (life satisfaction and depression) are above  $r = .70$ , which might imply different scales measuring the same concepts.

Table 11  
Correlation Coefficient between Variables in The Caregiving Stress Process

	1	2	3	4	5	6	7
1. Filial Obligation	--	.17*	.22**	.54***	-.47***	.40***	-.16*
2. Caregiving Tasks		--	-.10	-.25**	.03	-.18*	.04
3. Social Support			--	.21**	-.40***	.22**	-.51***
4. Caregiving Satisfaction				--	-.33***	.46***	-.15*
5. Caregiving Burden					--	-.33***	.41***
6. Life Satisfaction						--	-.33***
7. Depression							--

\*\*\* p < .001    \*\* p < .01    \* p < .05

#### Other Intervening Variables

The previous section examined the results of the study's major research hypotheses. In this section, Pearson's correlation coefficients between other intervening variables, which are not included in the research hypotheses, and major variables in the caregiving stress process were examined. A step-wise multiple regression was run to understand the predictors in explaining the variance of caregiving outcomes (life satisfaction and depression).

Table 12 summarizes the correlation coefficients between four intervening variables (caregivers' age, caregivers' educational level, the length of marriage, and caregivers' health condition) and variables in the caregiving stress process. The results indicated that caregivers' age had moderate positive relationships with the level of filial

obligation ( $r = .42, p < .001$ ) and caregiving tasks ( $r = .60, p < .001$ ). However, age was negatively related to the level of caregiving burden ( $r = -.216, p < .01$ ). This finding implies that older caregivers were more likely to feel higher levels of filial obligation and more likely to experience greater levels of caregiving tasks. In contrast, younger caregivers were more likely to experience higher levels of caregiving burden.

Caregiver's educational level was positively related to the level of social support ( $r = .26, p < .001$ ) which indicated that caregivers with higher levels of education were likely to feel higher levels of social support. Higher levels of education were likely to provide caregivers with chances to access available support and services.

The results also indicated that the length of marriage was very positively related to the level of caregiving tasks ( $r = .60, p < .001$ ) and filial obligations ( $r = .42, p < .001$ ). The findings suggest that caregivers who were married longer were likely to experience higher levels of caregiving tasks and filial obligation. Length of marriage is also related to older caregivers who are more likely to have been raised with a stronger sense of filial obligation. Longer marriage would also imply older caregivers, which would be connected to the age of care recipients. Eventually, the age of care recipients would be related to the levels of caregiving tasks.

The level of health condition of caregivers showed a negative relationship with the levels of depression ( $r = -.31, p < .001$ ) and caregiving burden ( $r = -.21, p < .01$ ). The findings indicated that the better health condition of the caregivers, the lower levels of depression and caregiving burden the respondents were likely to experience.

Table 12

Correlation Coefficients between Four Intervening Variables and Major Variables on the Caregiving Stress Process.

Independent Variable	Dependent Variable	r
Age of caregivers	Filial obligation	.42 **
	Caregiving Tasks	.60 **
Education	Social Support	.26 **
Length of Marriage	Filial Obligation	.42**
Health Condition	Caregiver Burden	-.21*
	Depression	-.30**

\*\* p<.001, \* p<.01

Table 13 summarizes correlation coefficients between intervening variables (level of family income, age of the elderly, the elder's health, and length of caregiving) and the major variables in the caregiving process. Family income revealed a positive relationship with life satisfaction ( $r = .31$ ,  $p < .001$ ) and a negative relationship with caregiving burden ( $r = -.34$ ,  $p < .001$ ). The age of both parents-in-law were positively related to the level of filial obligation (father-in-laws;  $r = .38$ ,  $p < .001$ ; mother-in-laws;  $r = .31$ ,  $p < .001$ ), and the level of caregiving tasks (father-in-laws;  $r = .60$ ,  $p < .001$ ; mother-in-laws;  $r = .54$ ,  $p < .001$ ).

These findings indicate that the older the care receivers are, the higher the levels of filial obligation and the greater the numbers of caregiving tasks caregiving daughters-in-law are likely to have. The findings were likely related to the relationships between

caregivers' age and the level of filial obligation ( $r = .42$ ,  $p < .001$ ), and the length of marriage and the level of filial obligation ( $r = .42$ ,  $p < .001$ ), which is shown in Table 13. Older caregivers are more likely to have been married longer and to feel a greater level of filial obligation toward their parents-in-law.

Table 13

Correlation Coefficients between Intervening Variables and Major Variables on the Caregiving Stress Process.

Independent Variable	Dependent Variable	r
Family Income	Life Satisfaction	.31**
	Caregiving Burden	-.34**
Age of father-in-laws	Filial Obligation	.38**
	Caregiving Tasks	.60**
Age of mother-in-laws	Filial Obligation	.31**
	Caregiving Tasks	.54**
Elder's disease	Caregiving Tasks	.33**
Length of Caregiving	Caregiving Tasks	.56**

\*\* $p < .001$

Having physical or cognitive impairment of the elderly was positively related to the level of caregiving tasks ( $r = .33$ ,  $p < .001$ ). Caregivers who provide care to physically or cognitively impaired elders were likely to have more caregiving tasks. The length of caregiving was also positively related to the level of caregiving tasks ( $r = .56$ ,

$p < .001$  ). Therefore, the longer caregivers provide care for their elderly, the greater number of caregiving tasks they are likely to have.

Table 14 summarizes correlation coefficients between three intervening variables (quality of the relationship between caregivers and care recipients, between caregivers and husbands, and between caregivers and children) and the major variables in the caregiving process. First, the level of quality of the relationship between caregivers and their parents-in-law was positively related to the level of filial obligation ( $r = .46$ ,  $p < .001$ ), social support ( $r = .38$ ,  $p < .001$ ), caregiving satisfaction ( $r = .54$ ,  $p < .001$ ), and life satisfaction ( $r = .45$ ,  $p < .001$ ). They indicated that the better quality of the relationship between caregivers and the elderly, the higher levels of filial obligation, social support, caregiving satisfaction, and life satisfaction caregivers. However, the level of quality of the relationship between caregivers and care recipients was negatively related to the level of caregiving burden ( $r = -.53$ ,  $p < .001$ ) and depression ( $r = -.35$ ,  $p < .001$ ). Caregivers who had a bad relationship with their elderly were likely to report higher levels of caregiving burden and depression.

The level of quality of the relationship between caregivers and their husbands was positively related to the level of filial obligation ( $r = .36$ ,  $p < .001$ ), social support ( $r = .35$ ,  $p < .001$ ), caregiving satisfaction ( $r = .45$ ,  $p < .001$ ), and life satisfaction ( $r = .34$ ,  $p < .001$ ), while it was negatively related to the level of caregiving burden ( $r = -.55$ ,  $p < .001$ ) and depression ( $r = -.47$ ,  $p < .001$ ). These findings imply that the better relationship between caregivers and husbands was, caregivers were likely to experience higher levels of filial obligation, social support, caregiving satisfaction, and life satisfaction and lower levels of caregiving burden and depression.

The level of quality of the relationship between caregivers and children was positively related to the level of filial obligation (  $r = .40$ ,  $p < .001$  ), social support (  $r = .33$ ,  $p < .001$  ), caregiving satisfaction (  $r = .39$ ,  $p < .001$  ), and life satisfaction (  $r = .31$ ,  $p < .001$  ). It was also negatively related to the level of caregiving burden (  $r = -.48$ ,  $p < .001$  ) and depression (  $r = -.45$ ,  $p < .001$  ). The quality of the relationship between caregivers and children was related to the identified variables in the caregiving process; it seems that children's support for caregiving jobs would help caregivers feel less levels of burden and depression, and feel higher levels of caregiving satisfaction, life satisfaction, social support, and filial obligation.

Table 14

Correlation Coefficients between Three Quality of Relationships and Dependent Variables

Dependent Variables	Quality of Relationships Between Caregivers With		
	The Elder	Husband	Children
Depression	-.35**	-.47**	-.45**
Life Satisfaction	.45**	.34**	.31**
Caregiving Burden	-.53**	-.55**	-.48**
Caregiving Satisfaction	.54**	.45**	.39**
Social Support	.37**	.35**	.33**
Filial Obligation	.46**	.36**	.40**

Note. The values represent correlation coefficients (r) between the quality of the relationships and dependent variables. \*\* $p < .001$

The results of step-wise multiple regression analysis to assess the predictability of the intervening variables (caregivers' age, educational level, the length of marriage, health condition, age of the elderly, and so on) for caregiving outcomes (life satisfaction and depression) are presented in Table 15 and 16. Two regression models were presented for variables predicting the variance in life satisfaction.

The first model revealed that the level of quality of the relationship between caregivers and care-recipients was the only statistically significant predictor ( $\beta = .435$ ,  $p < .001$ ) in explaining the variance in life satisfaction ( $R^2 = .184$ ,  $p < .001$ ). The second regression model indicated that the quality of the relationship between caregivers and care recipients ( $\beta = .413$ ,  $p < .001$ ) and the level of family income ( $\beta = .217$ ,  $p < .001$ ) were statistically significant contributors in explaining the variance in life satisfaction ( $R^2 = .251$ ,  $p < .001$ ). Even though the quality of relationship between caregivers and care recipients and the level of family income were selected as predictors in explaining the variance in life satisfaction in the regression models, they only explained 18% and 25% of the variance in life satisfaction. Therefore, other variables, which have not been identified, explain the majority of the variance in life satisfaction for this sample of caregivers.



Table 15

Summary of Step-Wise Regression Analysis for Variables Predicting Life Satisfaction  
(N =140)

Variable	B	SE B	$\beta$
Model 1			
Quality of the relationship with the elder	2.567	.441	.435**
Model 2			
Quality of the relationship with the elder	2.379	.424	.413**
Family Income Level	2.417	.657	.271**

Note.  $R^2 = .18$  for Model 1 ( $p < .001$ ) ;  $R^2 = .25$  for Model 2 ( $p < .001$ ),

\*\* $p < .001$

The results of the step-wise regression analysis showed two regression models in predicting the variance in depression. The first model indicated that the quality of the relationship between caregivers and their husbands was the only statistically significant predictor ( $\beta = .489$ ,  $p < .001$ ) in explaining the variance in depression ( $R^2 = .234$ ,  $p < .001$ ). The second model showed that the quality of the relationship between caregivers and husbands ( $\beta = .433$ ,  $p < .001$ ), and caregivers' health condition ( $\beta = .158$ ,  $p < .05$ ) were statistically significant predictors in explaining the variance in depression ( $R^2 = .250$ ,  $p < .05$ ). Again, these factors explain only a small percentage in the variance in depression.

Table 16

Summary of Step-Wise Regression Analysis for Variables Predicting Depression  
(N =140)

Variable	B	SE B	$\beta$
Model 1			
Quality of the relationship with husband	.945	.143	.489**
Model 2			
Quality of the relationship with husband	.838	.152	.433**
Caregivers' health condition	.339	.169	.158*

Note.  $R^2 = .23$  for Model 1( $p < .001$ ) ;  $R^2 = .25$  for Model 2 (  $p < .05$  ),

\*\* $p < .001$ , \* $p < .05$

### Open-Ended Questions

To acquire a better understanding of the caregiving process in Korea, the following open-ended questions were asked: how were the respondents selected to be the primary caregivers for their parents-in-law, how much support did the respondents receive from their relatives or siblings, what were the major difficulties or problems in providing care for parents-in-law in the same household, and what were the major motives for providing care for parents-in-law.

First, answers to the question about how they were selected to be primary caregivers for their parents-in-law are summarized in the Table 17. Almost one fourth of the respondents (24.3%,  $n = 37$ ) mentioned that their husbands were the eldest or the only son in his family. As mentioned in chapter 2, Korean culture and tradition have imposed

the primary caregiving role for parents-in-law on the eldest daughters-in-law. Next frequent responses (17.8%, n = 27) were related to daughters-in-law's employment status and rearing their children. This response indicated that daughters-in-law with full time jobs provide care for the elderly to get help from the elderly with raising their children, while fulfilling their filial obligation. Interestingly enough, it implies that the caregiving process is not just one direction which goes from daughters-in-law to parents-in-law. The respondents also mentioned that they were helping each other. Some (15.1%, n =23) responded that they began to provide care for their parents-in-law, because one of parents-in-law passed away.

Table 17

Reasons to Be Selected As Primary Caregivers ( N =152 )

Item	<u>n</u>	%
Only son or eldest son	37	24.3
Caregiver's job status and their kids	27	17.8
Death of one of parent-in-law	23	15.1
Elderly wants to live together	19	12.5
Parent-in-law's age and bad health	11	7.2
Financial problems	10	6.6
Others	10	6.6
Second or third son	8	5.3
After marriage, lived together	7	4.6

Others (12.5%, n = 19) mentioned that parents-in-law wanted to live together, and they had no choice to accept their wishes, and 5.3% ( n = 8) answered they were second

or third son's wives, however, in most cases the eldest son was not available to provide care for the elderly. In addition, 7.2% ( n = 11) respondents mentioned that the elderly were sick and old, 6.6% ( n = 10) had financial reasons, and 4.6% ( n = 7 ) responded they lived with their parents-in-law after marriage.

To find out how much support these caregivers had from their relatives, what kinds of support or help they received from their siblings regularly or frequently was asked. The results are presented in the Table 18. Almost half of the respondents (41%, n = 61) had no support or help from their siblings, in addition, some siblings even expressed the feeling that providing care for their elderly was respondents' obligation and responsibility. On the other hand, 22.4% ( n =34 ) had all kinds of support from their siblings including emotional, monetary, and physical support, 7.2% ( n = 11) had monetary support from siblings, and 5.9% ( n = 9) had emotional support.

Table 18

Support from Relatives ( N = 152 )

Item	<u>n</u>	%
No support /help	62	40.8
All kinds of support /help	34	22.4
Thanks and appreciation without help	21	13.8
Others	15	9.9
Monetary support	11	7.2
Emotional support	9	5.9

Responses to the question about what the major problems or difficulties were in providing care for parents-in-law at the same household are summarized in the Table 19. Over one fifth of the respondents (n = 32) did not answer this question. The most frequent responses (38.4 %, n = 46) were difficulties in trying to match parents-in-law's characteristics and life styles, because it required caregivers to change in all aspects of their lives. These responses can be understood considering changes in Korean society and generational gaps between caregivers and care recipients. Almost 20 % ( n = 24 ) mentioned preparing meals as a difficulty for providing care for elderly. Especially, daughters-in-law who have full time jobs expressed preparing meals on time for their families and the elderly as one of difficulties.

Table 19

Major Problems or Difficulties in Caring for The Elderly ( N = 120 )

Item	<u>n</u>	%
Conflicts in characteristics and life styles	26	21.7
Preparing meals	24	20.0
Conflicts in thinking and opinion	20	16.7
The elderly's health condition	19	15.8
Dealing with own behaviors	13	10.8
No problem, comfortable	10	8.3
Others	8	6.7

Almost 16 % ( n =19) said that their difficulties are the elders' health problems, and 11 % ( n =13 ) responded the difficult thing was how to behave with the elderly. On the other hand, 10 respondents (8.3%) said that they have no difficulties in caring for the elderly in

the same household and they felt comfortable. Only eight respondents (6.7%) answered other difficulties such as managing their time, having worse relationship with their husband, having difficulties in going out, and so on.

Table 20 summarizes responses to the question about what were the major motives in caring for their parent-in-laws. Over half of the respondents ( n = 69) mentioned that the major motive was responsibility. Responsibility as the major motive for this sample can be understood, since almost one fourth of the respondents were the only son or the eldest son of the household, who are culturally bound to the obligation of providing care for their elderly instead of their own choice. One fourth of them ( n =29 ) answered both affection and responsibility as major motives, and only 3.3% ( n = 4 ) were only affection. Four respondents (3.3 %) stated that they felt sympathetic toward the elderly parents-in-law and nine (7.4%) stated that financial reasons were the major motives providing care for parents-in-law. Interestingly, six respondents mentioned that providing care for the elderly was helping them since they helped raising grandchildren, therefore, they believed helping each other was the major motive.

Table 20

The Major Motives for Caring The Elderly ( N = 121 )

Item	<u>n</u>	%
Responsibility	69	57
Affection and responsibility	29	24
Financial reasons	9	7.4
Helping each other	6	5.0
Affection	4	3.3
Sympathy	4	3.3

## CHAPTER 6

### DISCUSSION

This chapter discusses the findings of the study, presents implications for social work practice, public policy and programs, and provides the limitations and contributions of this study and implications for further study.

#### Findings of the Study

The primary purposes of the study are (1) to describe the relationships among the variables in the caregiving stress process and (2) to investigate the caregiving outcomes in providing care for the elderly in the same household in South Korea. The study also examines whether and to what extent filial obligation is related to the caregiving process and to what extent the identified variables in the stress process and other intervening variables are related to and predicted the variances in the caregiving outcomes.

The first hypothesis proposed the stress model. This model, which includes filial obligation, is a better predictor of primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (life satisfaction and depression) than the model without filial obligation. The proposed stress process model that includes filial obligation explains significantly more variance in primary subjective stressors (caregiving satisfaction and caregiving burden) in the caregiving process than the model without filial obligation. However, the findings suggest that the proposed model including filial obligation makes little difference in explaining the variance in caregiving outcomes (depression and life satisfaction) when compared with the stress

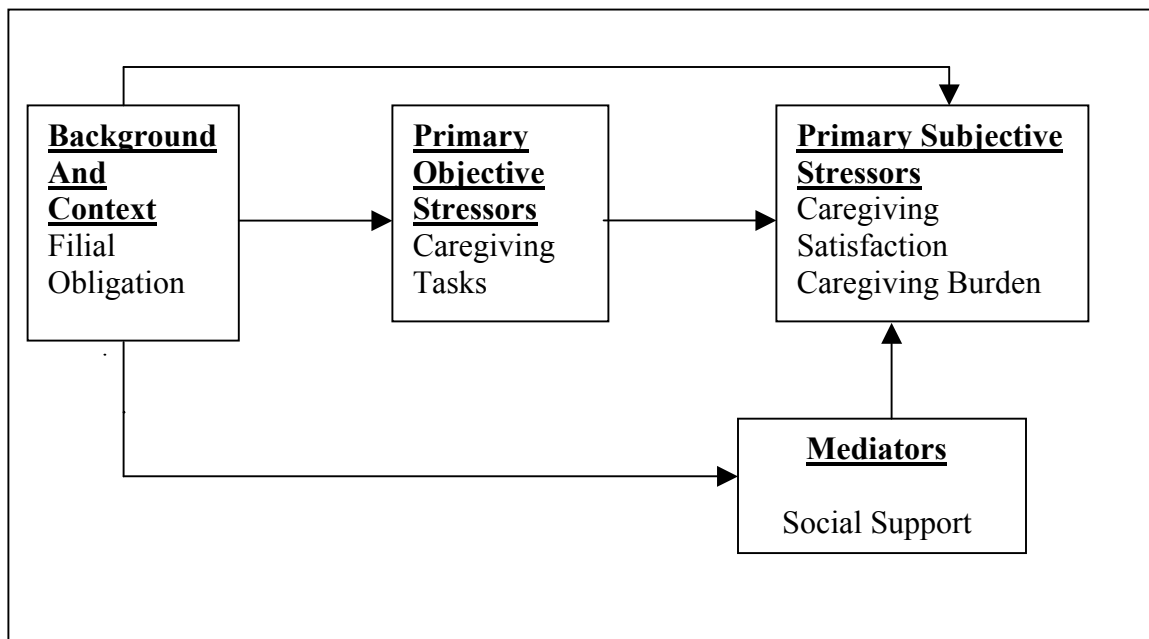
process model that excludes filial obligation. Therefore, the findings of the study suggest that including filial obligation in the model results in more variance explained in caregiving satisfaction and caregiving burden, while it makes no difference in explaining the variance in life satisfaction and depression.

In the final regression model for life satisfaction, caregiving satisfaction is the most powerful and statistically significant contributor ( $\beta = .29$ ,  $p < .001$ ) to the variance in life satisfaction. In addition, filial obligation is the most powerful contributor to the variance in caregiving satisfaction ( $\beta = .49$ ,  $p < .001$ ). Therefore, even though filial obligation has no statistical significance in the final regression model for life satisfaction, it is thought that filial obligation is likely to impact life satisfaction indirectly through caregiving satisfaction. So, daughters-in-law who have a stronger sense of filial obligation are more likely to have a greater sense of caregiving satisfaction and eventually more likely to have a greater sense of life satisfaction.

The final regression model for depression also indicates that caregiving burden is one of the more important variables in explaining variance in depression. In addition, filial obligation is also the most powerful and statistically significant contributor to the variance of caregiving burden ( $\beta = -.42$ ,  $p < .001$ ). Even though filial obligation does not have a statistically significant relationship with depression directly, filial obligation is likely to impact depression indirectly through caregiving burden. This indicates that caregiving daughters-in-law with less sense of filial obligation are likely to experience a greater sense of caregiving burden, which results in a greater sense of depression. Based on these findings, two separate caregiving stress process models (see Figure 3, and Figure 4) might be suggested.

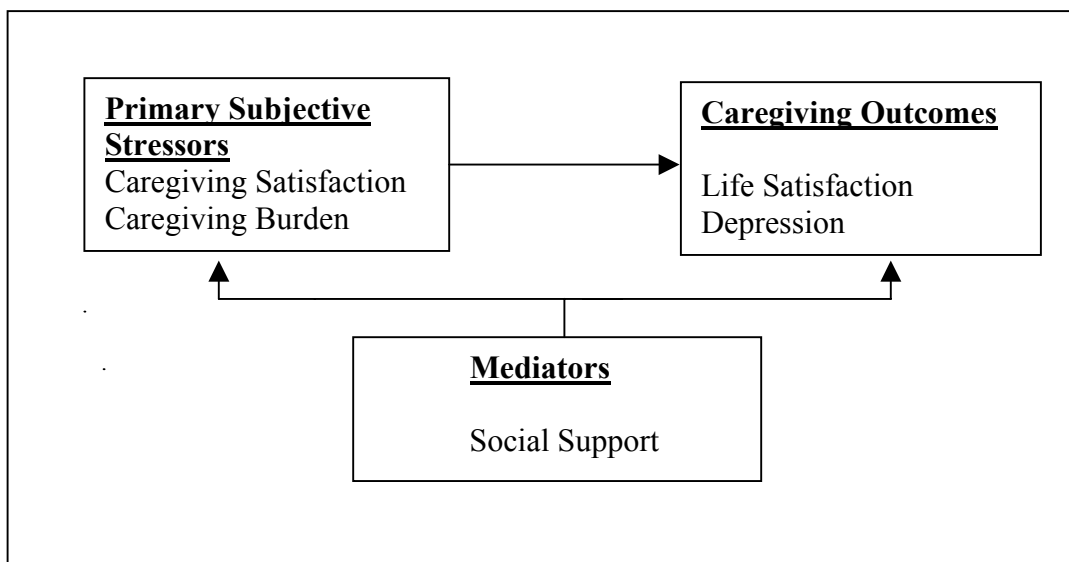


The research model is further separated between primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (life satisfaction and depression) in the caregiving process. Including the background and context variable, filial obligation, makes a significant contribution to the overall variance in primary subjective stressors (caregiving satisfaction and caregiving burden) directly and indirectly (see figure 3). Therefore, the first model would be focused on the stress process, from the background and context variables through the primary subjective stressors (caregiving satisfaction and caregiving burden). This indicates that the level of filial obligation is likely to impact on the level of caregiving satisfaction and caregiving burdens indirectly (through the levels of caregiving tasks) and directly through caregiving outcomes.



**Figure 3.** The Stress Process Model Based on the Findings of the Study

The findings clearly indicate the importance of filial obligation in the family caregiving process, especially, daughters-in-law providing care for their parents-in-law in Korea. For instance, caregiving daughters-in-law with higher levels of filial obligation are likely to feel higher levels of caregiving satisfaction and lower levels of caregiving burden. In addition, the mediating variable, social support, which was considered to influence the level of the primary objective stressor (caregiving tasks) in the proposed research model, was not supported by the findings of the study. The model only indicates the direct impact of social support on the primary subjective stressors.



**Figure 4.** The Stress Process Model Based on the Findings of the Study

The second stress process model would be focused on explaining the stress process from the primary subjective stressors through caregiving outcomes. The findings of the study do not support the direct relationships between filial obligation and

caregiving outcomes (life satisfaction and depression), so, unlike Figure 2 in chapter 3, the direct contribution of filial obligation in caregiving outcomes is omitted in Figure 4.

Additionally, the relationships between social support and the primary subjective stressors, and between social support and caregiving outcomes were supported by the findings of the study, so they would be presented in the model. The findings only support the indirect relationships between filial obligation and caregiving outcomes (life satisfaction and depression) through the primary subjective stressors (caregiving satisfaction and caregiving burden). Therefore, the second stress model (see Figure 4) would present only the relationships between the primary subjective stressors (caregiving satisfaction and caregiving burden) and caregiving outcomes (life satisfaction and depression). Eventually, this second model indicates that the level of filial obligation of caregivers would not impact the level of depression or life satisfaction, but would impact the level of caregiving satisfaction and caregiving burden, which would then impact the level of life satisfaction and depression.

The findings indicate that caregivers with greater filial obligation are likely to perform a greater number of caregiving tasks and experience a higher level of caregiving satisfaction. The level of social support did not affect this relationship. In addition, caregivers with a greater sense of filial obligation are likely to experience lower levels of caregiving burden regardless of the level of social support. So, daughters-in-law who are oriented toward more traditional Korean culture are likely to accept and perform the role of primary caregivers under less emotional stress compared with those who are oriented Western culture.

The findings of the study also indicate that caregiving tasks are negatively associated with caregiving satisfaction and life satisfaction; however, caregiving tasks have no statistically significant relationship with caregiving burden and depression. It is suggested that the level of caregiving tasks only impacts the positive aspects of caregiving process, and is not related to the negative aspects of caregiving. This aspect would be explained by both the characteristics of the elders in this study and the cultural context. Only half of the respondents provided care for parents-in-law with physical or/and cognitive impairment, and most of the remainder of them provided care for the elderly with normal health conditions. Even the sick elderly were not in serious medical condition. So the main reason that the respondents provide care for their parents-in-law was the responsibility toward their parents-in-law bound by traditional culture. Korean daughters-in-law provide care for their parents-in-law not only under special circumstances, like elder's sickness or being alone, but also under general circumstances, like the elder's wanting to live with them. Under this circumstance, the level of caregiving tasks would not be an important aspect, as was expected. Findings from the open-ended questions of the study reflect the general conditions of caregiving situations in Korea, indicating the major problems or difficulties in caring for the elderly are conflicts between caregivers and parents-in-law in terms of characteristics and life styles. While conflicts in characteristics between caregivers and care recipients refer to problems from personal or individual aspects, conflicts in life style are the results of societal changes in Korea. These findings also imply that caregiving daughters-in-law in this study consider conflicts with the elderly as more serious than the level of caregiving tasks.

In addition, the level of filial obligation is moderately associated with the caregiver's age and length of marriage. Results seem to be congruent with those of the previous study (Choi, 1993), which indicate differences in the level of filial obligation by the generations; traditional values and norms regarding selection of the primary caregiver are in transition. For instance, caregivers in their 50's are congruent with cultural and traditional expectations and tend to feel higher level of filial obligation toward providing care for the elderly, while caregivers in their 30's are congruent with both traditional and modern expectations and tend to feel lower levels of filial obligation. Furthermore, the length of marriage shows a positive relationship with levels of filial obligation. The length of marriage indicates the length of the relationship between caregivers and care-receivers. Because the sample was caregiving daughters-in-law, who were linked to their husband's family through marital ties, the length of marriage indicates the period of shared history and the level of potential assimilation into husband's family culture. Therefore, daughters-in-law who have been married longer would be more emotionally involved in their husbands' family, so they would sense greater levels of filial obligation toward their parents-in-law.

Findings of caregiving satisfaction, caregiving burden and caregiving outcomes in South Korea provide the chance to examine the similarities and differences to those findings in the U.S. There are considerable similarities; length and duration of providing care, the availability of social support, and caregiver's health condition are significantly associated with caregiver burden and caregiving outcomes in both countries. In addition, the findings of the study indicate that the level of quality of the relationships between caregivers and care receivers, husbands, and children is strongly related to caregiving

variables such as caregiving burden and caregiving satisfaction. Because care receivers were their husband's parents, the quality of the relationship between daughters-in-law and their husbands was an influence on the caregiving outcomes. The previous study in the U.S. also suggested that the level of quality of the relationship between caregiving daughters-in-law and their parents-in-law, and between caregivers and husbands is significantly related to caregiver burden and satisfaction (Merril, 1994).

However, as Choi (1993) suggested the finance-related variable was the difference between these two countries; the finding of this study also indicates that level of family income is related to caregiver burden, and caregiving outcomes in South Korea. For instance, the higher the family income, the lower levels of caregiving burden, and the higher the levels of life satisfaction felt by Korean caregivers, however, this is not true in the U.S. studies. This difference would be explained by the differences in public programs for the elderly in both countries. In addition, it must be pointed out that this study's findings of a negative relationships between filial obligation and caregiving burden is incongruent with studies conducted in the U.S. (Raveis, Karus, & Pretter, 1999; Cicirelli, 1993; Albert, 1992), which revealed a positive relationship between filial obligation and caregiving burden. This would be explained by the cultural difference tie to filial obligation in Korea and the U.S., disclosing the inverse direction of associations between filial obligation and caregiving burden. For instance, filial obligation is strongly related to the amount of help provided to elderly parents, which would be considered, generally, children's responsibility rather than a burden in Korean cultural context (Lee, & Sung, 1998 ). On the other hand, in the U.S. filial obligation is also associated with the amount of help provided to elderly parents, however, it would be considered a burden

instead of a responsibility (Cicirelli, 1993) This suggests that filial obligation bound to cultural background is a strong component in explaining the caregiving process in both countries.

#### Implications for Social Work Practice

Findings of the study also suggest implications for social work practice. The traditional value in Korea placed on family care for the elderly endorses that daughters-in-law are able to cope effectively with potential conflict, balancing their own daily lives and caregiving responsibilities. These findings indicate that many daughters-in-law provide care for their parents-in-law out of responsibility, in spite of the sacrifices. Many daughters-in-law reveal that they were all alone in providing care, so their burdens were high. Social workers working in the gerontological area need to target services to relieve the burden of caregiving daughters-in-law, especially, to those who feel that there are no alternative to being a caregiver and to those who have little or no assistance in providing care. For instance, social workers and those who coordinate community care can help to empower caregivers and delineate the positive aspects of alternative situations. Social workers working with families can also help potentially reduce caregiver stress by counseling families to share caregiving responsibilities where possible. It is important to focus on reducing caregivers' stress and experiences which generate negative caregiving conditions, because they can lead to or create additional problems, such as the neglect and abuse of the elderly. Therefore, providing targeting services to relieve the stress of caregivers is directly related to the well-being of both the caregivers and the elderly.

As mentioned early, the consequences of social, demographic, and values changes have influenced Korean society, and moved daughters-in-law beyond their

traditional roles. For instance, women in their twenties and thirties in Korea are often employed themselves, and sometimes they reject the cultural norms that have delegated caregiving tasks to them. Therefore, one possible solution would be for Korean society to provide greater assistance in caregiving and homemaking tasks so that family members can still uphold their family values and fulfill their filial obligations by providing care in their homes. In addition, social workers need to challenge the Korean cultural notion that home care is the best way of providing care for the elderly regardless of the condition of the elderly. Currently, adult children who institutionalize their parents are considered to lack family values. Realistically, however, informal family home care is not always the most appropriate care for the elderly. For instance, the elderly who have dementia or are most at risk for injury may be better off in a nursing home than in the home. Therefore, it is incumbent on social workers to help Korean society recognize the appropriateness of institutionalization in the above cases and to provide support to families providing care for the elderly in nursing homes.

Finally, to improve the situation of family caregivers, social workers need to consider the family as a single unit when developing support groups, educational programs and even respite services for caregivers. Results of the study indicate that over 40% of caregiving daughters-in-law do not have any kind of support from their relatives and siblings. However, a previous study found that siblings and relatives offered important sources of social support in family caregiving situations in the US (Cicirelli, 1991). Therefore, social workers working with families need to find ways to involve the whole family in the caregiving process that would not only reduce the burden for the caregiver at present but also improve their chances for social support in the future.



### Implications for Public Policy and Program

Based on the findings of the study, filial obligation associated with traditional and cultural attitudes was strongly related to family caregiving practice. Throughout the history of Korea, it has been a preferred traditional family pattern for elderly parents and adult children to live in the same household, and so far social pressure has enforced it. However, this tradition is breaking down in modernized Korean society. As a result, there need to be changes on the part of the elderly's perspective, society, and government. As indicated in the findings, the caregivers' family members, relatives, and most importantly, care receivers and caregiver's spouse can influence the level of caregivers' experience of caregiving practices. There is a need for the development of educational and support programs for caregivers, the elderly, and their family members, such as self-help and professional counseling programs that improve mutual understanding, coping and communication skills, and informal support networking.

Another finding of this study also suggested a need for a government funded programs and services for the elderly population and their family caregivers. Given the findings that older caregivers had stronger sense of filial obligation coupled with Choi's (1993) finding that younger caregivers were less traditional in their thinking, it appears that it may be difficult to keep the current level of family caregiving practice in the future in Korea. Therefore, the government's active involvement in meeting the changing care needs of the elderly and their family caregivers is necessary to promote the well-being of the elderly and preserve family caregiving.

### Limitations and Contributions

Limitations of this study include its cross-sectional design, non-random selection of subjects, and reliance on self-reported data. The study did not employ a random design, so potential sampling biases are inherent. The sample was drawn from caregiving daughters-in-law who provided care for parents-in-law in the same households and who lived in the selected apartments in Taegu. The study was conducted in Taegu, a mid-sized, urbanized, industrialized, still conservative city in Korea. The findings of this study would not represent whether and to what extent the cultural values and norms would have had different impacts on caregiving process in rural or the most Westernized urban areas.

According to Rubin and Babbie (1997), having 10 subjects for each variable is appropriate. Based on the recommendation, a sample size of 35 to 70 would be the minimum required sample for this study, because there were 7 variables in the major hypotheses. However, some researchers recommend over 200 subjects for the cross-sectional survey design study, because it has less control over the independent variables (Isaac, & Michael, 1995). According to this recommendation, the lack of sample size in this study limits the power of the design and the control of measurement errors.

This study attempts to test a stress process model, which was developed in the U.S., within the context of Korean culture. While it provides a useful conceptual framework and information for better understanding of Korean family caregiving practices and the chance to compare caregiving practice in other countries, the study had some cultural limitations.

First, the study has some limitations in applying measurement scales developed for use in the U.S. to the Korean culture and language. As pointed out in the findings chapter, the Caregiver Burden Scale, Interpersonal Support Evaluation List (ISEL), and Scale for Filial Obligation were difficult to translate into Korean. Specifically, some items in these scales were apparently interpreted in different ways by caregivers from the two countries, because the cultural expectations regarding family relationships and perceptions of exact meanings of some wordings were different in these two countries. Consequently, the modified The Caregiver Burden Scale and ISEL were employed in this study. The Caregiver Burden scale was already translated and modified based on the results of factor analysis on the Korean caregivers in the previous studies, and ISEL were also modified using factor analyses on Korean immigrants in the US. The scale for filial obligation showed that one item had item-to-total correlations of less than .20, with negative correlations with more than three of the other items with the sample in this study. Even though the decision made to use the original 13-item scale in this study due to a minor difference in the Cronbach's alpha level after dropping the item, some respondents expressed difficulty in answering the question. This difficulty indicates developing and using appropriate and relevant scales within their own cultural background seems to be a critical aspect in the study of caregiving in Korea.

Secondly, even though filial obligation, the primary subjective stressors (caregiving satisfaction and caregiving burden), and other intervening variables showed statistical significance in explaining the variance in caregiving process, these variables explained small percentages in the variance in caregiving outcomes. There might be several reasons in explaining small amount of variance explained ( $R^2$ ). There are clearly

other factors which are not included in the study that explain more variance in caregiving outcomes (life satisfaction and depression) in this sample. Due to lack of information regarding the caregiving process in Korea, all variables in the study were selected from the previous studies in the U.S. Therefore, important factors that could explain the variance of caregiving outcomes may have been missed. In addition, life satisfaction and depression might not represent caregiving outcomes of daughters-in-law's caregiving experiences in Korea, as it did in the Western culture.

Furthermore, this study narrowly focused its operational definition of cultural factors on the level of filial obligation of caregivers. Therefore, if the study examined much broader cultural factors, including caregiver's viewpoints toward the traditional status and roles as a daughter-in-law, an elderly person, or a family member, the findings related to the influence of cultural factors on family caregiving practice and caregiving outcomes might have been different from those in this study.

Finally, the study has limitations in generalizing the findings beyond the participants' caregiving practices because the findings of the study do not provide a whole picture of family caregiving patterns in Korea. This limitation is related to the sample and purpose of the study, which focused on daughters-in-law in caring for parents-in-law at the same households, culturally a typical family caregiving structure in Korea. Therefore, the findings of the study did not portray the caregiving experience with different family structures in Korea. For instance, no son in the family, the son still unmarried, daughters caring for their own parents, daughters-in-law caring for parents-in-law at an agency or hospital were not explored in this study, though they would also provide useful information regarding caregiving experiences.

### Directions for Further Study

In spite of the above limitations, the study offers empirical data on family caregiving practice, especially daughters-in-law caring for their parents-in-law in the same household in Korea. Recognizing the study's weaknesses and limitations would be very useful for further family caregiving studies. There are several recommendations for further research. For instance, representative family caregiving structure and practices utilizing a random sampling method, a longitudinal study examining family caregiving practice in the same household or with a hospitalized elderly parents, and a qualitative or case study about caregivers' attitudes toward providing care balancing cultural and traditional norms and modernization would be suggested. In addition, it would be very helpful to find out the experience of other caregiving family members in addition to those of the primary caregivers.

## REFERENCES

- Aimei, J. (1988). New experiments with elderly care in rural China. Journal of Cross-Cultural Gerontology, 3, 139-148.
- Albert, S. M. (1992). Psychometric investigation of a belief system: Caregiving to the chronically ill parent. Social Science and Medicine, 35, 699-709.
- Aldwin, C.M., Spiro, A., Levenson, M.R., & Bosse, R. (1989). Longitudinal findings from the normative aging study: Does mental health change with age? Psychology and Aging, 4, 295-306.
- Alley, J. (1988). Family Caregiving: Family strains, coping response patterns, and caregiver burden. Unpublished doctoral dissertation, Virginia Polytechnic Institute and State University, Virginia.
- Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlatch, C. J. (1995). Profiles in caregiving: The unexpected career. Academic Press.
- Barusch, A. (1995). Programming for family care of elderly dependents: Mandates, incentives, and service rationing. Social Work, 40, 315-322.
- Attitude of young Korean men toward the elderly. (1994, March 29). Hankuk Ilbo, P. B9.
- Berg-Weger, M. (1996). Caring for elderly parents: The relationship between stress and choice. New York : Garland Publishing.

- Boaz, R.F., Hu, J., & Ye, Y. (1999). The transfer of resources from middle-aged children to functionally limited elderly parents: Providing time, giving money, sharing space. The Gerontologist, 39, 648-657.
- Brislin, R. W. (1976). Translation: Applications and research. New York: Gardner Press.
- Brickman, P. (1987). Commitment. In C. B. Wortman & R. Sorrentino (Eds.), Commitment, conflict and caring (pp.1-18). Englewood Cliffs, NJ: Prentice-Hall.
- Broberg, M., Melching, D. E., & Maeda, D. (1975). Planning for the elderly in Japan. The Gerontologist, 15, 242-247.
- Brodman, K., Erdmann, A.J., Wolff, H.G., & Miskovitz, P.F. (1986). The Cornell medical index health questionnaire manual. New York: Cornell University Medical College.
- Brody, E. M. (1985). Parent care as a normative family stress. The Gerontologist, 25, 19-29.
- Brody, E. M., Litvin, S.J., Hoffman, C., & Kleban, M. H. (1995). Marital status of caregiving daughters and co-residence with dependent parents. The Gerontologist, 35, 75-85.
- Brody, E.M., Litvin, S.J., Hoffman, C., & Kleban, M.H. (1992). Differential effects of daughters' marital status on their parent care experiences. The Gerontologist, 32, 58-67.
- Burack-Weiss, A. (1995). The caregiver's memoir: A new look at family support. Social Work, 40, 391-395.

- Burton, L. C., Newsom, J. T., Schulz, R., Hirsch, C.H., & German, P.S.(1997).  
Preventive health behaviors among spousal caregivers. Preventive Medicine, 26,  
162-169.
- Caffrey, R. A. (1992). Caregiving to the elderly in Northeast Thailand. Journal of Cross-  
Cultural Gerontology, 7, 117-134.
- Cantor, M. H. (1983). Strain among caregivers:A study of experience in the United  
States. The Gerontologist, 23, 597-604.
- Cantor, M. H. (1991). Family and community: Changing roles in an aging society. The  
Gerontologist, 31, 337-345.
- Chenoweth, B., & Spencer, B. (1986). Dementia: The experience of family caregivers.  
The Gerontologist, 26, 267-272.
- Cho, H. (1986). Labor force participation of women in Korea. In S. Chung (Eds),  
Challenges for women(pp.24-47). Seoul: Ewha Womans University Press.
- Choi, G. (1997). Acculturative stress, social support, and depression in Korean American  
families. Journal of Family Social Work, 2, 81-97.
- Choi, J. S.(1970). Comparative study on the traditional families in Korea, Japan and  
China. In R. Hill & R. Koenig (Eds.), Families in East and West (pp. 202-210).  
Paris: Mouton.
- Choi, H. (1993). Cultural and noncultural factors as determinants of caregiver burden for  
the impaired elderly in South Korea. The Gerontologist, 33, 8-15.
- Choi, H. (1992). The process of caregiving stress among caregivers for the elderly in  
Korea: Social support, coping, and psychological health. Unpublished dissertation.  
University of Minnesota, Minneapolis.



- Choi, S. J. (1989). The ideal of filial piety and the welfare of the aged. Korean Journal of Social Welfare, 13, 1-25.
- Cicirelli, V.G. (1983). Adult children's attachment and helping behavior to elderly parents: A path model. Journal of Marriage and the Family, 45, 815-825.
- Cicirelli, V. G. (1993). Attachment and obligation as daughters' motives for caregiving behavior and subsequent effect on subjective burden. Psychology and Aging, 8, 144-155.
- Cicirelli, V.G. (1991a). Family caregiving: Autonomous and paternalistic decision making. Newbury Park, CA: SAGE Publications.
- Cicirelli, V. G. (1991b). Helping elderly parents: The role of adult children. Boston, MA: Auburn House Publishing Company.
- Clark, M., & Standard, P. (1996). Caregiver burden and the structural family model. Family Community Health, 18(4), 58-66.
- Clipp, E.C., & George, L.K.(1990). Caregiver needs and patterns of social support. Journal of Gerontology: Social Sciences, 45, 102-111.
- Cohen, S., Mermelstein, R., Kamarck, T., & Hoberman, H. (1985). Measuring the functional components of social support. In G. Sarason & B.R. Sarason (Eds.), Social support : Theory, research, and application (pp. 73-94). The Hague, The Netherlands: Martinus Nijhoff.
- Connell, C. (1994). Impact of spouse caregiving on health behaviors and physical and mental health status. The American Journal of Alzheimer's Care and Related Disorders and Research, January/February, 26-36.

- Connell, C., Gibson, G. (1997). Racial, ethnic, and cultural differences in dementia caregiving: Review and analysis. The Gerontologist, 37, 355-364.
- Connidis, I. A. (1994). Sibling support in older age. The Journals of Gerontology: Social Sciences, 49, S309-S317.
- Cowgill, D. (1986). Aging around the world. Belmont, CA: Wadsworth.
- Cowgil, D. (1972). Aging in American society. In D. Cowgill, & L. Holmes (Eds.) Aging and Modernization, (pp.243-261). New York: Meredith Corporation.
- Cowgill, D., & Holmes, L. (1972). Summary and conclusions: The theory in review. In D. Cowgill & L. Holmes (Eds.), Aging and Modernization (pp. 262-284). New York: Meredith Corporation.
- Cummings, S. M., Kelly, T.B., Holland, T.P., & Perterson-Hazan, S. (1998). Development and validation of the needs inventory for caregivers of the hospitalized elderly. Research on Social Work Practice, 8, 120-132.
- Cutrona, C.E., & Russell, D.W. (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B.Sarason, I. Sarason, & G.Pierce (Eds.), Social support: An interactional view (pp. 319-366). New York: Wiley.
- Dautzenberg, M., Diederiks, J., Philipsen, H., & Tan, F. (1999). Multigenerational caregiving and well-being: Distress of middle-aged daughters providing assistance to elderly parents. Women and Health, 29(4), 57-74.
- Dilworth-Anderson, P. , & Anderson, N.B. (1994). Dementia caregiving in Blacks: A contextual approach. In B. Lebowitz, E. Light, & G. Neidereche (Eds.), Mental and physical health of Alzheimer's caregivers (pp. 385-409). New York: Springer.

- Dixon, J. (1981). The Chinese welfare system: 1949-1979. New York: Praeger.
- Doty, P. (1986). Family care of elderly: The role of public policy. Milbank Memorial Fund Quarterly, *64*, 34-75.
- Drachman, D., Kwon-Ahn, Y.H., & Paulino, A. (1996). Migration and resettlement experiences of Dominican and Korean families. Families in Society: The Journal of Contemporary Human Services, *77*, 626-638.
- Dubos, R. (1959). Mirage of health: Utopias, progress, and biological change. New York: Harper & Row (Perennial Library).
- Dunkel-Schetter, C., & Bennett, T. (1990). Differentiating the cognitive and behavior interactional view (pp. 267-296). New York: Wiley.
- Dura, J.R., Stukenberg, K.W., & Kiecolt-Glaser, J.K. (1990). Chronic stress and depressive disorders in older adults. Journal of Abnormal Psychology, *99*, 284-290.
- Dura, J.R., Stukenberg, K.W., & Kiecolt-Glaser, J.K. (1991). Anxiety and depressive disorders in adult children caring for demented parents. Psychology and Aging, *6*, 467-473.
- Economic Planning Board (1990). Population and housing census report. Seoul: Economic Planning Board.
- Economic Planning Board (1986). Social indicators. Seoul: Economic Planning Board.
- Farran, C. (1997). Theoretical perspectives concerning positive aspects of caring for elderly persons with dementia: Stress/adaptation and existentialism. The Gerontologist, *37*, 250-256.

- Fischer, L. S. (1986). Linked lives: Adult daughters and their mothers. New York: Harper and Row.
- Foner, N. (1984). Age and social change. In D.L. Kertzer & J. Keith (Eds.), Age and anthropological theory. Ithaca NY: Cornell University Press.
- Formanek, S., & Linhart, S. (1997). Aging Asian concepts and experiences: Past and present. Verlag: Wein.
- Freed, A. O. (1990). How Japanese families cope with fragile elderly. Journal of Gerontological Social Work, 15, 39-56.
- Fuller-Jonap, F. & Haley, W. E. (1995). Mental and physical health of male caregivers of a spouse with Alzheimer's disease. Journal of Aging and Health, 7, 99-118.
- Gallagher, S. (1994). Doing their share: Comparing patterns of help given by older and younger adults. Journal of Marriage and the Family, 56, 567-578.
- Gallant, M., & Connell, C. (1998). The stress process among dementia spouse caregivers: Are caregivers at risk for negative health behavior change? Research on Aging, 20, 267-297.
- Gallup-Korea (1984). Koreans' life and social attitudes. Seoul: Korea Gallup Polls Ltd.
- Gallup-Korea (1990). Life Style and value system of the aged in Korea. Seoul: Korea Gallup Polls Ltd.
- George, L. K. (1996). Social factors and illness. In R. H. Binstock & L. K. George (Eds.), Handbook of aging and the social sciences (pp. 229-252). San Diego: Academic Press.

- George, L.K., & Gwyther, L. P. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. The Gerontologist, 26, 253-260.
- Gevalnik, J., & Simonsick, E. (1993). Physical disability in older Americans. The Journal of Gerontology, 48, 3-10.
- Globerman, J. (1994). Balancing tensions in families with Alzheimer's disease: The self and the family. Journal of Aging Studies, 8, 211-232.
- Guberman, N., Maheu, P., & Maille, C. (1992). Women as family caregivers: Why do they care? The Gerontologist, 32, 607-617.
- Hale, D., Cochran, C., & Hedgepeth, B. (1984). Norms for the elderly on the brief symptom inventory. Journal of Counseling and Clinical Psychology, 52, 321-322.
- Haley, W., West, C., Wadley, V., Ford, G., White, F., Barrett, J., Harrell, L., & Roth, D. (1995). Psychological, social, and health impact of caregiving: A comparison of Black and White dementia family caregivers and noncaregivers. Psychology and Aging, 10, 540-552.
- Hareven, T. (1978). Family time and historical time. In A.S. Rossi & P.H. Rossi (Eds.), The family (pp. 57-70). New York :Norton.
- Harris, P.B., & Long, S. O. (1999). Husbands and sons in the United States and Japan: Cultural expectations and caregiving experiences. Journal of Aging Studies, 13, 241-267.
- Himes, C. L. (1994). Parental caregiving by adult women: A demographic perspective. Research on Aging, 16, 191-211.

- Hinrichsen, G. A., & Ramirez, M. (1992). Black and white dementia caregivers: A comparison of their adaptation, adjustment, and service utilization. The Gerontologist, *32*, 375-390.
- Hirschfeld, M. (1983). Caring for the caregivers of the elderly. In M. Gergener, E.L. Lehr, & R. Schmitz-Scherzer (Eds.), Aging in the eighties and beyond: Highlights of the 19<sup>th</sup> international congress of gerontology. New York: Springer.
- Hirshorn, B.A., & Piering, P. (1998-1999). Older people at risk: Issues and intergenerational responses. Generations, *22*(4), 49-53.
- Hong, S. (1980). Korean women at work. Korea Journal, *24*, 4-37.
- Horowitz, A. (1985). Family caregiving to the frail elderly. In C. Eisdorfer (Ed.), Annual Review of Gerontology and Geriatrics (Vol. 5, pp. 196-246). New York: Springer.
- Horowitz, A., & Shindelman, L. W. (1983). Reciprocity and affection: Past influences on current caregiving. Journal of Gerontological Social Work, *5*, 5-20.
- House, J. S. (1981). Work stress and social support. Reading, MA: Addison-Wesley.
- House, J., Umberson, D., & Landis, K. (1988). Structures and processes of social support. Annual Review of Sociology, *14*, 293-318.
- Howard, L. (1994). Filial responsibility and informal support among family caregivers of the elderly in Jerusalem: A path analysis. International Journal of Aging and Human Development, *38*, 137-151.
- Hu, Y. H. (1995). Elderly suicide risk in family contexts: A critique of the Asian family care model. Journal of Cross-Cultural Gerontology, *10*, 199-217.
- Increases of elderly population in South Korea. (1993, June 19). Hankuk Ilbo, P. C3

- Isaac, S., & Michael, W. B. (1995). Handbook in research and evaluation. San Diego, CA: EdITS.
- Jarret, W. H. (1985). Caregiving within kinship system: Is affection really necessary? The Gerontologist, *25*, 5-10.
- Kauh, T.O. (1997). Intergenerational relations: Older Korean-Americans' experiences. Journal of Cross-Cultural Gerontology, *12*, 245-271
- Keith, P., & Hong, S. (1994). Depressive symptoms of younger and older Korean married women. Journal of Comparative Family Studies, *15*, 223-231.
- Kiecolt-Glaser, J. K., Dura, J.R., Speicher, C.E., Trask, O.J., & Glaser, R. (1991). Spousal caregivers of dementia victims: longitudinal changes in immunity and health. Psychosomatic Medicine, *53*, 345-362.
- Killeen, M. (1990). The influence of stress and coping on family caregivers perceptions of health. International Journal of Aging and Human Development *30*, 197-211.
- Kinney, J.M., & Stephens, M.A.P. (1989). Caregiving hassles scale: Assessing the daily hassles of caring for a family member with dementia. The Gerontologist, *29*, 328-332.
- Kim, C., & Rhee, K. (1997) Variations in preferred living arrangements among Korean elderly parents. Journal of Cross-Cultural Gerontology, *12*, 189-202.
- Kohout, F., Berkman, L., Evans, D., & Cornoni-Huntley, J. (1993). Two shorter forms of the CES-D depression symptoms index. Journal of Aging and Health, *5*, 179-193.
- Kong, S., Park, I., Cho, A., Kim, J., & Chang, H. (1987). Change in Korean family structure. Seoul: The Korean Institute for Health and Social Affairs.

- Kramer, B. J. (1993a). Expanding the conceptualization of caregiver coping: The importance of relationship-focused. Family Relations: Interdisciplinary Journal of Applied family Studies, 42, 383-391.
- Kramer, B. J. (1997). Gain in the caregiving experience: Where are we? What next? The Gerontologist, 37, 218-232.
- Kramer, B. J. (1993b). Marital history and the prior relationship as predictors of positive and negative outcomes among wife caregivers. Family Relations: Interdisciplinary Journal of Applied family Studies, 42, 367-375.
- Lawton, M., Kleban, M., Moss, M., Rovine, M., & Glicksman, A. (1989). Measuring caregiver appraisal. Journal of Gerontology: Psychological Sciences, 44, 61-71.
- Lawton, M., Moss, M., Kleban, M., Glicksman, A., & Rovine, M. (1991). A two-factor model of caregiving appraisal and psychological well-being. Journal of Gerontology, 46, 181-189.
- Lazarus, R. S. & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.
- Lee, D. (1995). The Korean perspective on death and dying. In J.K. Parry & A. Shen Ryan (Eds.), A cross cultural look at death, dying and religion (pp. 193-214). Chicago: Nelson-Hall.
- Lee, I., Kim, I., & Lee, J. (1999). A study on family structure of the Korean elderly. International Journal of Welfare for the Aged, 1, 95-107.
- Lee, M. (1999). Looking for a new paradigm for the motives of parent care. International Journal of Welfare for the Aged, 1, 123-132.



- Lee, G. R., Netzer, J., & Coward, R. (1994). Filial responsibility expectations and patterns of intergenerational assistance. Journal of Marriage and the Family, 56, 559-565.
- Lee, Y., & Sung, K. (1998). Cultural influences on caregiving burden: Cases of Koreans and Americans. International Journal of Aging and Human Development, 46, 125-141.
- Li Chi (1879-85). Sacred books of the east. I & II (J. Legge, Trans.) London: Oxford.
- Li, F.C. (1987). The Confucian way (pp. 376-409). London: Routledge & Kegan Paul.
- Merrill, D. M. (1993). Daughter-in-law as caregivers to the elderly: Defining the in-law relationship. Research on Aging, 15, 70-91.
- Merrill, D.M. (1997). Caring for elderly parents: Juggling work, family, and caregiving in middle and working class families. Westport, CT: Greenwood Publishing Group.
- Miller, B. (1989). Adult children's perceptions of caregiver stress and satisfaction. The Journal of Applied Gerontology, 8, 275-293.
- Miller, B., McFall, S., & Montgomery, A. (1991). The impact of elder health, caregiver involvement, and global stress on two dimensions of caregiver burden. Journal of Gerontology, 46, S9-19.
- Miller, B., & Lawton, M. (1997). Introduction: Finding balance in caregiver research, The Gerontologist, 37, 216-217.
- Montenko, A. (1989). The frustrations, gratifications, and well-being of dementia caregivers. The Gerontologist, 29(2), 166-172.
- Montgomery, R. (1989). Investigating caregiver burden. In K. Markides, & C. Cooper (Eds.), Aging, stress and health (pp. 56-89). New York: Wiley.

- Montgomery, R., & Hirshorn, B. (1991). Current and future family help with long-term care needs of the elderly. Research on Aging, 13, 171-204.
- Montgomery, R., Gonyea, J., & Hooyman, N. (1985). Caregiving and the experience of subjective and objective burden. Family Relations, 34, 19-26.
- Montgomery, R., Stoll, D., & Borgatta, E. (1985). Measurement and the analysis of burden. Research on Aging, 7, 137-152.
- Moen, P. (1994). Women, work, and family: A sociological perspective on changing roles. In M.W. Riley, R.L. Kahn, & A. Foner (Eds.), Age and structural lag (pp. 151-170). New York: John Wiley and Sons.
- Moroney, R. M. (1976). The family and the state: Considerations for social policy. New York: Longman.
- Moss, M., Lawton, M.P., Dean, J., Goodman, M., & Schneider, J. (1987, November). Satisfactions and burdens in caring for impaired elder persons. Paper presented at the annual meeting of the Gerontological Society of America, Washington, DC.
- Mui, A.C. (1995). Caring for frail elderly parents: A comparison of adult sons and daughters. The Gerontologist, 35, 86-93.
- Mui, A. C., & Morrow-Howell, N. (1993). Sources of emotional strain among the oldest caregivers: Differential experiences of siblings and spouses. Research on Aging, 15, 50-69.
- Murphy, J. F. (1990). Positive consequences of elderly spousal caregiving. Paper presented at the annual meeting of the Gerontological Society of America Washington, D.C.

- Naleppa, M. J. (1996). Families and the institutionalized elderly: A review. Journal of Gerontological Social Work, 27(1/2), 87-109.
- Noelker, L.S., & Townsend, A. L. (1987). Perceived caregiving effectiveness: The impact of parental impairment, community resources, and caregiver characteristics. In T. H. Brubaker (Ed.), Aging, health, and family: Long-termcare (pp. 58-79). Newbury Park, CA: Sage.
- Novak, M., & Guest, C. (1989). Application of a multidimensional caregiver burden inventory. The Gerontologist, 29, 798-803.
- Ory, M., Hoffman, R., Yee, J., Tennstedt, S., & Schulz, R. (1999). Prevalence and impact of caregiving: A detailed comparison between dementia and nondementia caregivers. The Gerontologist, 39, 177-185.
- Otten, A.L. (1989). People patterns. Wall Street Journal, March 20, P.B1.
- Pallett, P. (1990). A conceptual framework for studying family caregiver burden in Alzheimer's-type dementia. Image: Journal of Nursing Scholarship, 22(1), 52-58.
- Palmaore, E., & Maeda, D. (1985). The honorable elders revisited. Durham, NC: Duke University Press.
- Pak, J. K. (1985). Problems of the aged in the 21<sup>st</sup> century and the private support function. Korean Journal of Gerontology, 5, 54-61.
- Parish, W. L., & Whyte, M. K. (1978). Village and family in contemporary China. Chicago, IL: The University of Chicago Press.
- Park, C. H. (1983). Historical review of Korean confucianism. In Main currents of Korean thoughts (pp.26-82). The Korean National Commission for UNESCO. Seoul: The Sisayongosa.

- Pearlin, L. I. (1992). The careers of caregivers. The Gerontologist, *32*, 647.
- Pearlin, L. I. (1993). The social contexts of stress. In L. Goldberger & S. Breznitz (Eds.), Handbook of stress: Theoretical and clinical aspects (pp.303-315). The Free Press.
- Pearlin, L. I. (1985). Social structure and processes of social support. In S. Cohen & S. L. Syme (Eds.), Social support and health (pp.43-60). Academic Press.
- Pearlin, L. I., & Lieberman, M. A. (1979). Social sources of emotional distress. In R. Simmons (Ed.), Research in community and mental health, (Vol. 1, pp. 217-248). Greenwich, CT.: JAI Press.
- Pearlin, L.I., Lieberman, M.A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. Journal of Health and Social Behavior, *22*, 337-356.
- Pearlin, L.I., Mullan, J.T., Semple, S.J., & Skaff, M. M. (1990). Caregiving and the stress process: An overview of concepts and their measures. The Gerontologist, *30*, 583-594.
- Piercy, K. W., & Blieszner, R. (1999). Balancing family life: How adult children link elder-care responsibility to service utilization. The Journal of Applied Gerontology, *18*, 440-459.
- Pratt, C., Schmall, V., & Wright, S. (1987). Ethical concerns of family caregivers to dementia patients. The Gerontologist, *27*, 632-638.
- Rakowski, W., Fleishman, J.A., Mor, V., & Bryant, S.A. (1993). Self-assessments of health and mortality among older person: Do questions other than global self-rated health predict mortality? Research on Aging, *15*, 92-116.

- Raveis, V.H., Karus, D., & Pretter, S. (1999). Correlates of anxiety among adult daughter caregivers to a parent with cancer. Journal of Psychosocial Oncology, 17(3-4), 1-26.
- Raveis, V. H., Siegel, K., & Sudit, M. (1990). Psychological impact of caregiving on the caregiver: A critical review of research methodologies. In D. E. Biegel & A. Blum (Eds.), Aging and caregiving (pp. 53-75). Newbury Park, CA: Sage.
- Richardson, R. C., & Sistler, A. B. (1999). The well-being of elderly Black caregivers and noncaregivers: A preliminary study. Journal of Gerontological Social Work, 31, 109-117.
- Rim, C. (1999). A subject of social services of the Korean old-age welfare. International Journal of Welfare for the Aged, 1, 199-208.
- Rossi, A.S., & Rossi, P.H. (1990). Of human bonding: Parent child relations across the life course. New York: Aldine.
- Rubin, A., & Babbie, E. (1997). Research methods for social work. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Salhouse, T.A., Kausler, D. H., & Saults, J. S. (1990). Age, self-assessed health status, and cognition. Journal of Gerontology, 45, 156-160.
- Schulz, J. H ., & Davis-Friedmann, D. (1987). Aging China: Family, economics, and government policies in transition. Proceedings of the International Forum on Aging, Beijing, China, May 20-23, 1986. Washington, DC: The Gerontological Society of America.
- Schulz, R., Visintainer, P., & Williamson, G.M. (1990). Psychiatric and physical morbidity effects of caregiving. Journal of Gerontology, 45, 181-191.

- Seelbach, W. C., & Sauer, W. J. (1977). Filial responsibility expectations and morale among aged parents. The Gerontologist, *17*, 492-499.
- Shanas, E. (1968). Old people in three industrial societies. New York: Atherton.
- Sheehan, N.W., & Donorfio, L. M. (1999). Efforts to create meaning in the relationship between aging mothers and their caregiving daughters: A qualitative study of caregiving. Journal of Aging Studies, *13*, 161-176.
- Silverstein, M., Burholt, V., Wenger, G., & Bengtson, V. (1998). Parent-child relations among very old parents in Wales and the United States: A test of modernization theory. Journal of Aging Studies, *12*, 387-409.
- Silverstein, M., Parrott, T. M., & Bengtson, V. L. (1995). Factors that predispose middle-aged sons and daughters to provide social support to older parents. Journal of Marriage and the Family, *57*, 465-475.
- Smith, G.C. (1995). Preventive approaches to building competencies. In G.C. Smith, S.S. Tobin, E.A. Robertson-Tchabo, & P.W. Power (Eds.), Strengthening aging families: Diversity in practice and policy (pp.205-220). Thousand Oaks, CA: Sage.
- Soerensen, S. (1998). Predictors of anticipating caregiving in multigeneration families: An exploratory study. Journal of Applied Gerontology, *17*, 499-520.
- Soh, C.S. (1997). The status of the elderly in Korean society. In S. Formanek & S. Linhart (Eds.), Aging Asian concepts and experiences: Past and present (pp.177-195). Verlag:Wien.
- Spence, J. T. (1985). Achievement American style: The rewards and costs of individualism. American Psychologist, *40*, 1285-1295.

- Starrels, M., Ingersoll-Dayton, B., Dowler, D., & Neal, M. (1997). The stress of caring for parent: Effects of the elder's impairment on an employed, adult child. Journal of Marriage and the Family, *59*, 860-872.
- Stephens, M.A., Franks, M.M., & Townsend, A.L. (1994). Stress and rewards in women's multiple roles: The case of women in the middle. Psychology and Aging, *9*, 45-52.
- Stetz, K. (1986). The experience of spouse caregiving for persons with advanced cancer. Unpublished doctoral dissertation, University of Washington, Seattle.
- Stommel, M., Given, C. W., & Given, B. (1990). Depression as an overriding variable explaining caregiver burdens. Journal of Aging and Health, *2*, 81-102.
- Stone, R., Cafferata, G., & Sangl, J. (1987). Caregivers of the frail elderly: A national profile. The Gerontologist, *27*, 616-626.
- Stone, R., & Kemper, P. (1989). Spouses and children of disabled elders: How large a constituency for long-term care reform. The Milbank Quarterly, *64*, 485-506.
- Strawbridge, W.S. (1991). The effects of social factors on adult children caring for older parents. Dissertation Abstracts International, *52*, 1094.
- Strawbridge, W. S., & Wallhagen, M. (1991). Impact of family conflict on adult child caregivers. The Gerontologist *31*, 770-777.
- Stuckey, J., & Smyth, K. (1997). The impact of social resources on the Alzheimer's disease caregiving experience. Research on Aging, *19*, 423-441.
- Stuckey, J., Neundorfer, M., & Smyth, K. (1996). Burden and well-being : The same coin or related currency? The Gerontologist, *36*, 686-693.

- Suitor, J. J., Pillemer, K., Keeton, S., & Robison, J. (1995). Aged parents and aging children: Determinants of relationship quality. In R. Blieszner & V. H. Bedford (Eds.), Handbook of aging and the family (pp. 223-242). Westport, CT: Greenwood Press.
- Sung, K. (1995). Measures and dimensions of filial piety in Korea. The Gerontologist, 35, 240-247.
- Sung, K. (1994). A cross-cultural comparison of motivations for parent care: The case of Americans and Koreans. Journal of Aging Studies, 8, 195-209.
- Sung, K. (1991). Family-centered informal support networks of Korean elderly: The resistance of cultural traditions. Journal of Cross-Cultural Gerontology, 6, 431-447.
- Sung, K. (1990). A new look at filial piety: Ideals and practices of family-centered parent care in Korea. The Gerontologist, 30, 610-616.
- Thompson, Jr., E., Futterman, A., Gallagher-Thompson, D., Rose, J., & Lovett, S. (1993). Social support and caregiving burden in family caregivers of frail elders. Journal of Gerontology: Social Sciences, 48, S245-S254.
- Tonti, M. (1988). Relationships among adult siblings who care for their aged parents. In M.D. Kahn & K. G. Lewis (Eds.), Siblings in therapy: Lifespan and clinical issues (pp. 417-434). New York: Columbia University Press.
- Toseland, R., Smith, G., & McCallion, P. (1995). Supporting the family in elder care. In G.C. Smith, S.S. Tobin, E. A. Robertson-Tchabo, & P.W. Power (Eds.), Strengthening aging families: Diversity in practice and policy (pp. 3-24). Thousand Oaks, CA: Sage.



- Wagner, E. H., LaCroix, A.Z., Grothaus, L.C., & Hecht, J.A. (1993). Responsiveness of health status measures to change among older adults. Journal of the American Geriatrics Society, *41*, 241-248.
- Walker, A. (1996). The relationship between the family and the state in the care of older people. In J. Quadagno & D. Street (Eds.), Aging for the twenty-first century (pp. 269-285). New York: St. Martin's Press.
- Walker, A.J., & Pratt, C.C. (1991). Daughters help to mothers: Intergenerational aid versus caregiving. Journal of Marriage and the Family, *53*, 3-12.
- Walker, A. J., Pratt, C. C., Shin, H. Y., & Jones, L. L. (1990). Motives for parental caregiving and relationship quality. Family Relationships, *39*, 51-56.
- Wallhagen, M. I. (1990). Perceived control and adaptation in elderly caregivers. Unpublished doctoral dissertation, University of Washington, Seattle.
- Weitzner, M., & Knutzen, R. (1998). The impact of pituitary disease on the family caregiver and overall family functioning. Psychother Psychosom, *67*, 181-188.
- Wellman, B., & Wortley, S. (1990). Different strokes form different folks: Community ties and social support. American Journal of Sociology, *96*, 558-588.
- West, P. (1984). The family, the welfare state and community care. Journal of Social Policy, *13*, 417-446.
- Whittick, J. E. (1988). Dementia and mental handicap: Emotional distress in carers. British Journal of Clinical Psychology, *27*, 167-172.
- Yoo, S., & Sung, K. (1997). Elderly Koreans' tendency to live independently from their adult children: Adaptation to cultural differences in America. Journal of Cross-Cultural Gerontology, *12*, 225-244.

- Youn, G., & Song, D.(1992). Aging Koreans' perceived conflicts in relationships with their offspring as a function of age, gender, cohabitation status, and marital status. Journal of Social Psychology, 132, 299-305.
- Youn, G., Knight, B., Jeong, H., & Benton, D. (1999). Differences in familism values and caregiving outcomes among Korean, Korean American, and White American dementia caregivers. Psychology and Aging, 14, 355-364.
- Zarit, S.H., Orr, N. K., & Zarit, J. M. (1985). The hidden victims of Alzheimer's disease: Families under stress. New York: New York University Press.

## APPENDIX A

### THE INFORMED CONSENT FORM

#### THE STUDY

This study is part of an investigation of the caregiving process in South Korea. The purpose of the study is to learn how cultural factors affect the experience of daughters-in-law caring for their parents-in-law in home settings in South Korea. I am doing this study as part of my doctoral program at School of Social Work at the University of Georgia. The information gained from your participation will help provide better services to assist persons like yourself in caring for someone.

#### WHAT IS REQUIRED OF THE PARTICIPANTS?

The participants will be asked through a phone call to volunteer to complete the questionnaire. Participants who volunteer will be given the questionnaire which should take between 30 and 45 minutes. The questionnaire will then be mailed to the researcher in the pre-addressed stamped envelope or be picked it up personally.

#### WHAT IS MY BENEFIT AND RISK INVOLVING THIS RESEARCH ?

You may not personally benefit by participating in the study, however, your participation in this research will make a significant contribution to the enhancement of practice and research in the field of caregiving. There are no known physical or psychological risks in participating in this study. Some persons may feel temporary sadness in talking about the person they are caring for or about their own feelings. Remember, though, your participation is voluntary and you can refuse to answer at any time.

#### HOW WELL MY CONFIDENTIALITY BE PROTECTED?

The information you provide for this study will be kept confidential. Only my research advisor and I will access to it. Everything I collect from you will be identified by a code number, so that no names will appear on the data collection forms. The only place your name will appear is on this consent form, which will then be filed separately from your responses to the questions. When my report is written, only summary results will be reported. Should I want to use a specific statement to illustrate a point, I will camouflage your remarks so that it will be impossible to know who actually said what.

Your participation in this study is voluntary. You are free to withdraw from the study at any time without penalty or effect on any services or funding that you may be receiving. If you have any questions, you may contact Hyunji Park Lee (053) 653-6375 or the Institutional Review Board at the University of Georgia (706) 542-6514.

The study described above has been explained to me and I have had an opportunity to ask questions. I agree to participate in this research project which is conducted by Hyunji Lee, University of Georgia, School of Social Work, (706) 542-3364

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Signature of Participant

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Hyunji Park Lee  
University of Georgia  
School of Social Work  
Investigator

## APPENDIX B

## DEMOGRAPHIC INFORMATION

Age : \_\_\_\_\_ Birth year: \_\_\_\_\_

## Years of Education

8 or less	9 10 11 12	13 14 15 16	17 18 19 20+
	high School	College	Graduate School

(in Korean)

- |                       |                           |
|-----------------------|---------------------------|
| 1. Elementay graduate | 2. Middle school graduate |
| 3. High school        | 4. High school graduate   |
| 5. College            | 6. College graduate       |
| 7. Graduate School    |                           |

## Marital Status

1. Married 2. Divorced 3. Widowed 4. Separated 5. Single

Length of marriage to your current spouse \_\_\_\_\_year

Number of household \_\_\_\_\_

Number of your children \_\_\_\_\_

Do you have chronic physical condition? If yes, then how many do you have?

1 = NO 2 = Yes \_\_\_\_\_

What is your total family income level?

- |                        |                        |
|------------------------|------------------------|
| 1. Less than \$10,000  | 5. \$55,000-\$ 69,999  |
| 2. \$10,000-\$ 24, 999 | 6. \$ 70,000-\$ 84,999 |
| 3. \$25,000-\$39,999   | 7. \$ 85,000 and over  |
| 4. \$40,000-\$ 54,999  |                        |

(in Korean)

- |            |             |           |
|------------|-------------|-----------|
| 1. high    | 2. Mid-high | 3. middle |
| 4. mid-low | 5. low      |           |

Current work situation.

- |                       |                        |                       |
|-----------------------|------------------------|-----------------------|
| 1. Homemaker          | 2. Unemployed/laid off | 3. Full-time employed |
| 4. Part-time employed | 5. Self-employed       | 6. Volunteer work     |
| 7. In school          | 8. Retired             | 9. Other _____        |

Who are you providing care?

- |                   |                   |                         |
|-------------------|-------------------|-------------------------|
| 1 = mother-in-law | 2 = father-in-law | 3 = both parents-in-law |
|-------------------|-------------------|-------------------------|

Age of your parent-in-law(s). \_\_\_\_\_, \_\_\_\_\_

How long have you provided care for the elderly parents? \_\_\_\_\_ months

Does your elderly parents have physical or cognitive impairment?

- |         |        |
|---------|--------|
| 1 = Yes | 2 = No |
|---------|--------|

If yes, then please check the appropriate number.

- |                     |                         |                 |
|---------------------|-------------------------|-----------------|
| 1= physical problem | 2= Cognitive impairment | 3= Both of them |
|---------------------|-------------------------|-----------------|

How do you consider your relationship with your parents-in-law?

- |                   |              |                  |         |                 |             |                  |
|-------------------|--------------|------------------|---------|-----------------|-------------|------------------|
| 1                 | 2            | 3                | 4       | 5               | 6           | 7                |
| Extremely<br>Good | Very<br>Good | Somewhat<br>Good | Neutral | Somewhat<br>Bad | Very<br>Bad | Extremely<br>Bad |

## APPENDIX C

## CAREGIVING TASKS

Indicate the number which best describes about caregiving activities that you may or may not be doing now for care-receiver.

1 = Never

4 = Every week

2 = Rarely

5 = Several times a week

3 = Several times a month

6 = Every day

1. \_\_\_ I help care-receiver with eating his/her food.
2. \_\_\_ I help care-receiver with personal care (such as dressing, bathing, or hair care)
3. \_\_\_ I help care-receiver use the toilet, bedpan, or commode.
4. \_\_\_ I help care-receiver walk across the room.
5. \_\_\_ I help care-receiver get in and out of bed, chair, or couch.
6. \_\_\_ I plan care-receiver's meals.
7. \_\_\_ I prepare care-receiver's meals.
8. \_\_\_ I take care of care-receiver's banking, paying bills, or other financial matters.
9. \_\_\_ I do shopping, appointments, or run errands for care-receiver.
10. \_\_\_ I help care-receiver with writing letters, phone calls, or other personal communications.
11. \_\_\_ I help care-receiver with laundry or other household chores.
12. \_\_\_ I provide transportation for care-receiver in getting from home to other places.
13. \_\_\_ I help care-receiver take her medications and/or prescribed treatments.
14. \_\_\_ I contact doctor about care-receiver's medications and /or treatment needs.
15. \_\_\_ I check on care-receiver during the night.

## APPENDIX D

## LIFE SATISFACTION

Indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Slightly Disagree	Neither Agree Nor Disagree	Slightly Agree	Agree	Strongly Agree

1. \_\_\_\_\_ In most ways my life is close to my ideal.
2. \_\_\_\_\_ The condition of my life are excellent.
3. \_\_\_\_\_ I am satisfied with my life.
4. \_\_\_\_\_ So far I have gotten the important things I want in life.
5. \_\_\_\_\_ If I could live my life over, I would change almost nothing.



## APPENDIX E

## SOCIAL SUPPORT

For each statement we would like you to circle probably TRUE (T), if the statement is true about you or probably FALSE (F), if the statement is not true about you. Please read each item quickly but carefully before responding.

1. T F There is at least one person I know whose advice I really trust.
2. T F There is really no one I can trust to give me good financial advice.
3. T F There is really no one who can give me objective feedback about how I'm handling my problems.
4. T F When I need suggestions for how to deal with a personal problem I know there is someone I can turn to.
5. T F There is someone who I feel comfortable going to for advice about sexual problems.
6. T F There is someone I can turn to for advice about handling hassles over household responsibilities.
7. T F I feel that there is no one with whom I can share my most private worries and fears.
8. T F If a family crisis arose few of my friends would be able to give me good advice about handling it.
9. T F There are very few people I trust to help solve my problems.
10. T F There is someone I could turn to for advice about changing my job or finding a new one.
11. T F If I decide on a Friday afternoon that I would like to go to a movie that evening, I could find someone to go with me.
12. T F No one I know would throw a birthday party for me.

13. T F There are several different people with whom I enjoy spending time.
14. T F I don't often get invited to do things with others.
15. T F If I wanted to have lunch with someone, I could easily find someone to join me.
16. T F Most people I know don't enjoy the same things that I do.
17. T F When I feel lonely, there are several people I could call and talk to.
18. T F I regularly meet or talk with members of my family or friends.
19. T F I feel that I'm on the fringe in my circle of friends.
20. T F If I wanted to go out of town (e.g., to the coast) for the day I would have a hard time finding someone to go with me.
21. T F If some reason I were put in jail, there is someone I could call who would bail me out.
22. T F If I had to go out of town for a few weeks, someone I know would look after my home (the plants, pets, yard, etc.).
23. T F If I were sick and needed someone to drive me to the doctor, I would have trouble finding someone.
24. T F There is no one I could call on if I needed to borrow a car for a few hours.
25. T F If I needed a quick emergency loan of \$100, there is someone I could get it from.
26. T F If I needed some help in moving to a new home, I would have a hard time finding someone to help me.
27. T F If I were sick, there would be almost no one I could find to help me with my daily chores.
28. T F If I got stranded 10 miles out of town, there is someone I could call to come get me.
29. T F If I had to mail an important letter at the post office by 5:00 and couldn't make it, there is someone who could do it for me.
30. T F If I needed a ride to the airport very early in the morning, I would have a hard time finding anyone to take me.
31. T F In general, people don't have much confidence in me.
32. T F I have someone who takes pride in my accomplishment.

33. T F Most of my friends are more successful at making changes in their lives than I am.
34. T F Most people I know think highly of me.
35. T F Most of my friends are more interesting than I am.
36. T F I am more satisfied with my life than most people are with theirs.
37. T F I have a hard time keeping pace with my friends.
38. T F I think that my friends feel that I'm not very good at helping them solve problems.
39. T F I am closer to my friends than most other people.
40. T F I am able to do things as well as most other people.

## APPENDIX F

## FILIAL OBLIGATION

**Begin each statement with “Because she/he is my parent-in-law, I feel I should..”**

1 = Strongly Agree

3 = Moderately Disagree

2 = Moderately Agree

4 = Strongly Disagree.

1. \_\_\_ Give her/him emotional support even when it is not always convenient.
2. \_\_\_ be willing to give her/him financial help when necessary.
3. \_\_\_ help take care of him/her now that he/she is old and frail.
4. \_\_\_ be willing to adjust my work schedule in order to care for her/him.
5. \_\_\_ Be willing to share my home with him/her.
6. \_\_\_ be willing to sacrifice things I want for my own family or myself in order to care for him/her.
7. \_\_\_ be willing to make major changes in my life in order to care for him/her.
8. \_\_\_ be willing to do whatever it takes to keep caring for him/her at home.

**Read the following questions as is without introductory statement...**

9. \_\_\_ Family values are very important to me.
10. \_\_\_ I would feel guilty if I were not caring for my parents-in-law.
11. \_\_\_ I feel that my parent-in-law should try to rely more on his/her own resources rather than expecting me to help so much.
12. \_\_\_ I feel it would be better to develop more community resources to care for older persons like my parent-in-law rather than leaving it to adult children like me to provide care.
13. \_\_\_ I feel that persons with family or job responsibilities should not be expected to provide care for their aging parent-in-laws.

## APPENDIX G

## CAREGIVER BURDEN

Please answer the appropriate to you.

1 = Strongly Agree

3 = Disagree

2 = Agree

4 = Strongly Disagree

1. \_\_\_ My financial resources are adequate to pay for things that are required for caregiving.
2. \_\_\_ It is difficult to pay for care receiver's health needs and services.
3. \_\_\_ Caring for care receiver has put a financial strain on the family.
4. \_\_\_ My family works together at caring for care receiver.
5. \_\_\_ It is very difficult to get help from my family in taking care of care receiver.
6. \_\_\_ My family has done all they can to help with caring for care receiver.
7. \_\_\_ My activities are centered around care for care receiver.
8. \_\_\_ I have to stop in the middle of my work or activities to provide care.
9. \_\_\_ I have eliminated things from my schedule since caring for care receiver.
10. \_\_\_ The constant interruptions make it difficult to find time for relaxation.
11. \_\_\_ I visit family and friends less since I have been caring for care receiver.
12. \_\_\_ I am healthy enough to care for care receiver.
13. \_\_\_ I have enough physical strength to care for care receiver.
14. \_\_\_ I feel overwhelmed by the problems I have caring for care receiver.
15. \_\_\_ I resent having to take care of care receiver.
16. \_\_\_ I get very discouraged with caring for care receiver.

17. \_\_\_ Since caring for care receiver, sometimes I hate the way life has turned out.
18. \_\_\_ I feel I was forced into caring for
19. \_\_\_ I feel trapped by my caregiving role.
20. \_\_\_ At this time in my life, I don't think I should be caring for care receiver.

## APPENDIX H

## CAREGIVING SATISFACTION

Please check one the most fit to you.

1 = Strongly Agree

3 = Moderately Disagree

2 = Moderately Agree

4 = Strongly Disagree

1. \_\_\_ Caring for parent-in-law gives my self-esteem a boost.
2. \_\_\_ It helps to know that I am doing my best in caring for parent-in-law
3. \_\_\_ Caring for parent-in-law helps keep him/her from getting sicker than he/she otherwise would
4. \_\_\_ By providing care I am living up to my religious or moral principles.
5. \_\_\_ I have grown closer to parent-in-law as a result of caring for him/her
6. \_\_\_ I feel better about myself for being willing to care for parent-in-law
7. \_\_\_ I feel that there is more purpose and meaning in my life as a result of caring for parent-in-law
8. \_\_\_ Caring for parent-in-law has helped me realize that I can do things I never knew before that I could do
9. \_\_\_ I feel useful because I know I am helping someone
10. \_\_\_ Caring for parent-in-law has brought some of our family closer together
11. \_\_\_ Caring for parent-in-law has taught me to deal better with my emotions
12. \_\_\_ Caring for parent-in-law has taught me to distinguish the important things in life from the not-so-important
13. \_\_\_ I have been able to use special skills that I have to help parent-in-law continue to do the things that he/she enjoys doing
14. \_\_\_ Caring for parent-in-law has taught me some important things about myself
15. \_\_\_ Caring for parent-in-law gives me small but important uplifts now and then

## APPENDIX I

## SELF-RATED HEALTH SCALE

On a scale of 1 to 10 rate your health. Please circle the corresponding number.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
Very poor health Very good health



## APPENDIX J

## DEPRESSION

Please check the most appropriate one for your life recently.

0 = Hardly ever or never                      1 = Some of the time

2 = Much or most of the time

1. \_\_\_ I did not feel like eating; my appetite was poor.
2. \_\_\_ I felt depressed.
3. \_\_\_ I felt everything I did was an effort.
4. \_\_\_ My sleep was restless.
5. \_\_\_ I was happy.
6. \_\_\_ I felt lonely.
7. \_\_\_ people were unfriendly.
8. \_\_\_ I enjoyed life.
9. \_\_\_ I felt sad.
10. \_\_\_ I felt that people disliked me.
11. \_\_\_ I could not get "going".

## APPENDIX K

## OPEN ENDED QUESTIONS

How were you selected to be the primary caregiver for your parent-in-laws?

What about your brother or sister-in-laws? What kinds of help does each sibling provide?

What is the major problem or difficulty in providing care for your parent-in-laws at the same household?

What is your motivation for providing care for your parent-in-law(s)?

Your contribution to this effort is greatly appreciated. If you would like a summary of results, please print your name and address on the back of the return envelope (NOT on this questionnaire). We will see that you get them.