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Filial Responsibility and Transitions Involved: A Qualitative Exploration of Caregiving Daughters and Frail Mothers

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Abstract One of the consequences of an aging society is the growing need for caregivers to the increasing number of frail older persons. This study is a qualitative examination of filial responsibility between caregiving daughters and frail mothers. It explores filial expectations and motivations and how incongruencies are met and negotiated. Twenty-two women (eleven caregiving dyads) were interviewed using a semi-structured interview format. Employing the grounded theory methodology, interviews were analyzed both individually and dyadically for content and themes. What emerged from the analysis was a grounded theory framework of four intrapsychic caregiving and care-receiving transitions: (1) Realizing I am a Caregiver/Care-receiver; (2) Defining the Caregiver/Care-receiver Roles; (3) Redefining the Caregiving Relationship; and (4) Relationship Acceptance. The transitions identified here comprise a loose framework influenced by different levels of filial responsibility—personal, parental, family, and religious. In addition to the four transitions, one overarching theme called "Emotional Responses to Informal Caregiving and Care-receiving" was evident throughout the findings. Findings from this research provide a framework for understanding the often unclear transitions that daughters and mothers believe they go through. Research implications are discussed for researchers, therapists, caregiving support group leaders, and women who are contemplating or confronted with filial responsibility.

Keywords Filial responsibility · Caregiving transitions · Daughters caring for frail mothers

Introduction

Informal caregiving, once a personal matter in family life, is increasingly becoming a crucial issue in need of attention at societal and federal levels. The current health care delivery system, which includes shorter hospital stays, is shifting increasing responsibility for care of the elderly onto families with minimal support services (Feinberg and Newman 2004; Schulz and Martire 2004). A recent report released by "The Caregiving Project for Older Americans" (2006) estimates that over 15 million people over the age of 50 in the United States use caregiver services and of the 9.6 million who receive long-term care at home, 80% get their care entirely from family members. While informal caregiving is a cost-effective alternative to nursing home care, informal caregivers are a neglected group in the long-term care system despite the fact if informal caregiving had to be replaced with paid services it would cost $257 billion annually (Older Women's League 2006). Provision of physical, practical, and psychological care for informal caregivers has been described as "crisis intervention," since it is generally assumed that caregivers who appear to be coping and do not request education and support services have no "unmet needs" until a crisis occurs (Harding and Higginson 2003).

Understanding the unmet needs of adult caregivers and older care-receivers is of vital importance because of the inevitable demographic shift and the graying of our society.

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As “The Caregiving Project for Older Americans” (2006) report articulates, “Americans are poorly prepared to meet an inevitable ‘caregiving crisis’ as a result of population aging…. There is a growing gap between caregivers and the accelerated need for them”. While other countries have met caregiving challenges by adopting universal systems of long-term care (i.e., Japan, Germany, Austria) and explicitly recognizing and rewarding family care as part of their long-term-care continuum (Geraedts et al. 2000), the United States has no formal/universal caregiving system at all (The Caregiving Project for Older Americans, 2006; National Alliance for Caregiving, 2004). The only federal initiative to explicitly recognize and support family caregivers is “The National Family Caregiver Support Program,” charged with disseminating information to caregivers so they may better access supportive services (Wolff and Kasper 2006). Thus, it is even more crucial that we increase our efforts to meet the needs of family caregivers and their recipients.

One way we can attempt to better understand family needs is by identifying caregiving for an older parent as an intrapsychic process with identifiable transition points. This can provide a framework for examining the changes involved and a way to assess the unique needs and situations of caregivers and care-receivers, how they may be understood and helped by health care providers, mental health professionals, educational interventions, and support groups (Skaff et al. 1996).

This study uses a qualitative methodology to examine the filial expectations of caregiving daughters and their frail, widowed mothers and how they make sense out of their caregiving experience within the context of their relationship—past, present, and future. Employing a social constructivist paradigm, this research aims to capture the lived experiences of daughters and their aging mothers (Donorfio and Sheehan 2001). Because caring for a parent involves occupying a unique role, with implicit and explicit family and social rules, in-depth interviews were conducted and the grounded theory methodology (Strauss and Corbin 1990) employed. Unexpectedly, what evolved from the participant narratives was a complex “intrapsychic” process involving a framework of four distinct transition points.

While many caregiving studies have examined the relational dynamics of mothers and daughters, very few studies have explored the intrapsychic trajectories and adjustment patterns that daughters and mothers go through when in a caregiving relationship (Harding and Higgenson 2003). In a review of the literature (1966–2007), approximately 16 studies provide information on caregiving frameworks, including unique descriptive terms such as “caregiver career,” “stage,” “trajectory,” and “journey.” Table 1 summarizes the relevant study information. Overall, some describe a general model or offer a heuristic for stages of informal caregiving, while others have developed very specific temporal stages. Of the 16 articles cited, only two of these specifically incorporate the input of both caregiving family members and care-recipients (Bowers 1987; Shyu 2000).

Methodology

Grounded theory (Corbin and Strauss 1990) generates theory rather than builds on existing theory, requiring initial research questions to be open-ended, gradually narrowing as the researcher codes and analyzes the data. The initial research questions for this study were (Donorfio 1996):

1. What are the filial expectations of frail, widowed mothers and their caregiving daughters?
2. What, if any, are the intergenerational discrepancies between these filial expectations?
3. How are these discrepancies negotiated during the course of the caregiving relationship?

Participants

In accordance with grounded theory (Strauss and Corbin 1990), the sample was first selective, based on predetermined, reasonable criteria, and then theoretical, based on concepts that proved to be theoretically relevant to the evolving theory. Because over 70% of those providing and receiving informal care are women, this research initially selected a purposive sample of caregiving daughters and frail older mothers (Burr et al. 2007; Older Women’s League 2006). The initial dyads met the following criteria: mothers were frail, widowed, and free from cognitive impairment; mothers lived within 30 min of their daughters; daughters were primary caregivers as defined by both the mother and daughter; daughters provided at least three of the following services to mothers—housekeeping, transportation, meal preparation, laundry, personal care, and financial support (Walker and Allen 1991); daughters were between the ages of 45–60; daughters had received some form of post-secondary education; and daughters were from a middle class socioeconomic status (Donorfio 1996).

In being consistent with theoretical sampling, after the first four dyads were completed and analyzed, the selection criteria were revised, based on the evolving theory, to include: mothers of different frailty levels; mothers living more than 30 min away; daughters who were employed throughout the caregiving relationship; and daughters who had varying lengths of caregiving. Toward the end of the

Table 1 Psychological caregiving framework literature—1996–2006 (chronological order)

Author(s)	Year	Caregiver population	Care recipients	Research design	Caregiving stages
Bowers Interviewed caregivers and care-receivers	1987	Adult daughters (31), adult sons (2)	Elderly parents suffering various degrees of cognitive impairment	Qualitative, $n = 60$ Grounded Theory Caregivers = 33 Carereceivers = 27	Caregiving linked to stages of dementia: (1) anticipatory care, (2) preventative care, (3) supervisory care, (4) instrumental care, and (5) protective/preservative care
Sankar	1991	Spouses (10), adult children (3), parents (2), siblings (1). Women = 14	Family members of various ages and diseases	Qualitative, $n = 16$ In-depth ethnographic	Bereavement transitions: (1) separation, (2) liminality, and (3) reaggregation
Zarit and Whitlatch	1992	Wives (147), husbands (122), daughters (159)	Family members with dementia	Quantitative/Longitudinal, $n = 428$	Institutional placement transition phases—problems and stressors during and following placement, effect of placement on stress level, effects of institutionalization on intraindividual change
Lindgren	1993	Spouses. Women = 6	Various degrees of dementia/ Alzheimer's disease	Qualitative, $n = 10$ Open-ended interviews	Caregiver career: (1) encounter stage, (2) enduring stage, and (3) exit stage
Nolan, Keady, and Grant Reanalysis of Bowers (1987) above	1995	Adult daughters (31), adult sons (2)	Elderly parents suffering various degrees of cognitive impairment	Qualitative, $n = 60$ Grounded Theory Caregivers = 33 Carereceivers = 27	Family care typology: (1) anticipatory care, (2) preventive care, (3) supervisory care, (4) instrumental care, (5) protective care, (6) preservative care, (7) re-constructive care, and (8) reciprocal care
Boland and Sims	1996	Parents, spouses, adult children. Women = 14	Family members of various ages (1–87 years) No dementia, Alzheimer's disease, or mental illness	Qualitative, $n = 17$ Grounded Theory	Family caregiving as a solitary Journey: (1) burden, (2) responsibility, (3) isolation, and (4) commitment
Skaff, Pearlin, and Mullan	1996	Spouses, adult children	Family members with Alzheimer's disease	Quantitative/Longitudinal, $n = 456$	Transitions in the caregiving career: (1) continuing care (feeling trapped), (2) placement (a holding pattern), and (3) bereavement (a turning point)
Pfeiffer	1999	Family members	Family members with Alzheimer's disease	Descriptive: Heuristic developed via clinical practice working with families	Alzheimer's caregiving stages: (1) coping with the initial impact of being told the diagnosis, (2) to be or not to be a caregiver?, (3) at-home caregiving—the long journey, (4) considering institutional placement, (5) caregiving during residential or institutional placement, (6) death of the patient—grief and relief, and (7) resuming life—healing and renewal
Seltzer and Wailing	2000	Wives (214), daughters (262)	Family members over age 60	Quantitative/Longitudinal, $n = 476$	Caregiving transitions: (1) entry, (2) institutionalization, and (3) bereavement
Shyu Interviewed caregivers and care-receivers	2000	Spouses (5), adult children (11). Women = 9	Family members over age 65	Qualitative, $n = 28$ Caregivers = 16 Carereceivers = 12	Phases of role tuning: (1) Role engaging, (2) Role negotiating, and (3) Role setting
Montgomery and Kosloski	2000	Family members	Family members with Alzheimer's disease	Conceptual framework—formulated as a mechanism to understand diverse variations in caregiving	Caregiving career markers: (1) performance of initial caregiving tasks, (2) self-definition as a caregiver, (3) provision of personal care, (4) seeking out or using assistive services, (5) consideration of institutionalization, (6) actual nursing home placement, and (7) termination of the caregiver role

Table 1 continued

Author(s)	Year	Caregiver population	Care recipients	Research design	Caregiving stages
Smith, Folan, and Haaland	2002	Family members. Women = 39	Family members with Alzheimer's Disease	Qualitative, $n = 45$ Semi-structured interviews	Caregiving career: (1) early, (2) moderate, (3) late, and (4) bereavement
Burton, Zdaniuk, Schulz, Jackson, and Hirsch	2003	Spouses	Spouses	Qualitative and Quantitative Longitudinal, $n = 428$	Transitions in spousal caregiving: (1) moving into the caregiving role, (2) changes in caregiver status, (3) placement of spouse in a long-term care facility, and (4) spouse's death
Grant, Nolan, and Keady	2003	Family members	Family members	Descripitve: Heuristic developed to help support families with intellectual disability	Mapping temporality: (1) building on the past, (2) recognizing the need, (3) taking it on, (4) working it through, (5) reaching the end, and (6) a new beginning
Li	2005	Wives, daughters	Elderly family members	Quantitative/Longitudinal, $n = 157$	Trajectories of depressive symptoms
Guagler, Kane, and Newcomer	2007	Dementia caregivers. Women = 1,540	Care-recipients with dementia	Quantitative/Longitudinal, $n = 1{,}979$	Resilience and transitions from dementia caregiving: (1) institutionalization, (2) care recipient death, and (3) loss to follow-up

grounded theory analysis (after analyzing the eighth dyad), the selection criteria were revised once again to include daughters with no children; daughters who were homemakers; daughters who were widowed and divorced; and dyads of different living arrangements (e.g., shared household; duplex). The number of dyads interviewed was determined when the analysis revealed no new major themes (saturation). For the present study, saturation occurred after interviewing 22 women, 11 mother–daughter dyads.

All participants were volunteers and learned of the research through newspaper advertisements, flyers, personal contacts, and word of mouth recruitment strategies. All lived in the Northeast and were in the caregiving relationship for an average of 6.45 years (range: 1–17 years). One pair was African American and the remaining pairs white. The mean ages were 58 for the daughters and 81.5 for the mothers. Five daughters had no siblings and six between one and four. Seven daughters were married, one divorced, one single, and one widowed. Nine daughters had children (range: 1–8) and the remaining two had none.

Data Collection and Analysis

The author conducted, transcribed, coded, and analyzed the interview data over an 18-month period. The interviews were semi-structured and held in the homes of the participants, with the daughters being interviewed first. Participants were encouraged to answer all questions as thoroughly as possible and could refuse any question(s) and/or withdraw from the interview at any time. In addition to collecting pertinent demographic information, interview questions explored the following areas: relationship dynamics between the participant dyads; self-defined filial responsibility norms; and how filial discrepancies were negotiated within the mother-daughter relationship. Sample interview questions are presented in Appendix 1.

Following grounded theory protocol, data collection and analysis were done concurrently, with three levels of analysis being conducted—open coding, axial coding, and selective coding (Strauss and Corbin 1990). Research questions evolved as different theoretical categories emerged from the ongoing analysis. Open coding was done after each interview and a preliminary coding scheme developed. Axial coding was then done to examine the interrelationships and then selective coding to further develop and describe the findings. Throughout this entire process, the coding scheme was grounded in the daughters' interviews and then later linked to their mothers' interviews (Donorfio and Sheehan 2001).

Results

A grounded theory framework of four intrapsychic caregiving and care-receiving transitions emerged from the analysis of the interviews: (1) Realizing I am a Caregiver/Care-receiver; (2) Defining the Caregiver/Care-receiver Roles; (3) Redefining the Caregiving Relationship; and (4) Relationship Acceptance. The word "transitions" reflect what participants felt they went through—the newly acquired and required processes, changes, dynamics, and efforts in the making of the caregiving relationship.

With the unique variability inherent to each caregiving relationship, the transitions identified here comprise a loose framework influenced by different levels of filial responsibility—personal, parental, family, and religious. There are no associated timeframes with any of the transitions. While some of the women did progress through the transitions in a certain order, some experienced them in their own unique way, moving around and/or repeating them. The framework is not static but process driven. In addition to the four transitions, one overarching theme called "Emotional Responses to Informal Caregiving and Care-receiving" was extremely apparent throughout all the interviews and played an important part of each transition. The core category of filial responsibility will be presented first, followed by the over-arching theme of emotional responses, and then lastly, the four phase transitional framework.

Filial Responsibility Influences

The central phenomenon around which all the themes are integrated is filial responsibility. This core category is at the heart of the integration process and is the essential cement in pulling all the components together of the theory (Strauss and Corbin 1990). One of the primary objectives of this study was to explore the personal meaning of filial responsibility as it relates to being in a current informal caregiving relationship.

The only factor mentioned by all women, mothers and daughters, was personal. This factor was the most complex, reflecting basic motivations underlying the mother–daughter relationship. Personal motivators were love, respect, guilt, power, obligation, being responsible, companionship, fear of being alone, being able to live with oneself, feeling good, modeling for own children, and inheritance promises. As one daughter emphasized, "I love my parents very much and hopefully by caring for them I will get care back from my kids as an aging person."

Overall, the participants' meaning of filial responsibility reflected four primary influential factors: personal ($n = 22$), parental ($n = 12$), family ($n = 11$), and religious ($n = 7$). While each of the participant's personal meaning of filial responsibility did not include all four factors, each contained at least two of the factors.

Prior to being in the caregiving relationship, participants explained they had a vague awareness of filial responsibility. For many it existed on a superficial level, sparked only by exposure to situations experienced by friends, social networks (e.g., church), and/or the media, while for others it was experienced first hand via family norms and practice. Regardless of participants' exposure to other examples of filial responsibility around them, the possibility of receiving care or providing care was never formally discussed among these families.

Many participants felt that just by virtue of being or having a parent, informal care should be expected and/or given. Being a parent was seen as being unique and special and they should be repaid for all they have done. When a daughter was asked why she provided the help she did, she replied, "Why? Because she is my mother and it comes naturally." When asked the same question a mother replied, "She was my mother and that meant I should do what I could to help her out."

The nuclear family, as well as extended family, was seen as influential in providing care. Overall, the family was seen as having certain unspoken values that involved taking care of your parents that made the family separate and different from other societal groups. One mother simply stated, "I do feel that it is in our family values and that when people have it to give they have some obligation to help provide it. Family should be there for family." Religious beliefs were also cited as influencing the enactment of filial responsibility. When one mother was asked if she thought it was a child's responsibility to take care of his/her aging parent, she matter-of-factly stated, "Well, the church teaches you like that!"

Emotional Responses to Informal Caregiving and Care-receiving

The overarching theme of "Emotional Responses to Informal Caregiving and Care-receiving" was a very powerful one for the women involved in this research. Emotions were overwhelming and complex. Many felt isolated with no one to turn for consult or advice. When asked specifically what emotions they experienced, over 16 emotions were strongly identified across the interviews of both mothers and daughters. Table 2 provides a list of these

Table 2 Most common emotions experienced

Increased closeness	Denial
Helplessness[a]	Compassion
Hopelessness	Joy
Frustration[b]	Anger[b]
Guilt[a]	Duty
Empathy[b]	Obligation
Sadness	Satisfaction
Depression	Increased love

[a] Experienced more by mothers

[b] Experienced more by daughters

emotions (no given order). Three of the emotions were experienced more by daughters than mothers—frustration, empathy, and anger—while two of the emotions were mentioned more by mothers than daughters—helplessness and guilt. As one daughter shared: “Caregiving for me has been a rollercoaster ride of emotions. One minute I am angry and the next minute I am empathetic and then I am guilty. It is mentally exhausting.”

Framework

Transition 1: Realizing I am a Caregiver/Care-receiver

Many of the participants had a hard time seeing themselves as “true” caregivers/receivers which added much confusion to this transition (Donorfio 1996). When questioned about this, many associated providing or receiving care with attributes of a negative nature, strongly including those aspects involving total physical care. As one daughter had to explain convincingly to her mother, “I told her you need to understand what Laura’s definition of caregiving is because maybe what she considers and you consider are two different things. My mother considers a caregiver to be someone who comes in and gives you a bath, empties your bed pan and those kinds of things.” Another daughter discussed her changing definition of what a caregiver is and does, “Well it means, it means more than I realized because what I am doing is giving a certain amount of care but I am not really physically caregiving for her and that was what I originally thought about when I thought about what a caregiver does. If I never had to do this (she laughs), I wouldn’t have included what I am doing now in the definition of caregiving.”

Transition 2: Defining the Caregiver/Care-receiver Roles

Daughters and mothers were very involved in making sense out of their new and different roles. Some termed it a transition of “role ambiguity.” This transition was filled with many questions with no satisfying answers. Daughters commonly asked: What should be doing? How should I be doing it? Am I doing it right? As one daughter commented, “I don’t know what I should be doing that I am not. Do you know what I mean? I am not there 24 hours a day which some people are.” Mothers commonly asked: How dependent am I going to become? What has happened to my life? Where am I going to live? The majority of mothers felt guilty that their daughters had to provide assistance, even though they needed it. One mother shared, “I would rather be doing for myself… Yes, I want her to be helping me out because I need it. I am not as healthy as I used to be, but I feel guilty.”

This phase challenged mothers and daughters to move from a general awareness of filial responsibility, to a realization of actual feelings, tasks, and behaviors. For the first time, some of the women recognized emotional and conversational components as being part of their caregiving/receiving roles. One mother realized that the help she gives her daughter now is very different than what help she gave in the past. In the past she gave physical and monetary support, but now because of a decline in health and income, she provides emotional help (Donorfio 1996). With respect to the conversational component, a daughter conceives her new role as being someone who is there for her and someone for her to talk to. She states, “I am not talking about the closets, I am just talking about life in general.”

Part of defining one’s role involved renegotiating relationship boundaries with various family members. Most mothers had an awareness of their daughter’s responsibility to her nuclear family and somehow they were now on the outside looking in (Donorfio 1996). One mother related, “Yea know, after your children are married, you have to abide by what their husband’s say… I think probably they might want one thing and their husband wouldn’t and vice versa.” Daughters were aware of re-allocating time with their husbands and time and the struggle it took to make “everyone happy.”

Transition 3: Redefining the Caregiving Relationship

Daughters and mothers were very involved in making sense and meaning out of their new and different relationship. The relationship that was once mother and daughter is now caregiver and care-receiver. Some felt the relationship was being restructured both internally and externally. Filial responsibility was transformed from the general to the specific, blending old relational patterns with new caregiving responsibilities and realities. One daughter recognized a shift in the way she dealt with the changing status of her mother, “It was very frustrating because it is, like I remember what she was used to be like and what she is like now. It is much easier for me to deal with that now.” A mother points out, “You can’t turn back time or go back to the way a relationship used to be no matter what relationship it is… and we have just integrated it into everyday living.”

A strong element in this phase was what the participants termed “a new found age awareness.” For the first time, many of the women, both mothers and daughters, started to see themselves as being old and growing old. For mothers, a pronounced discrepancy was starting to be felt between their mental and physical self (Donorfio 1996). As one mother shared, "Most of the time I still do pretty well, but I keep saying I think the stroke killed my brain (she laughs) because I get mixed up and I know I get mixed up." Another mother added, "I forgot things but I know it and I can see [them in my mind] but I can't repeat [them]." For daughters, watching what age-related declines their mothers have experienced has caused them to think about the elders around them and what their aging will be like. Two daughters explained: "I am more empathetic to those aging around me and I am particularly aware of my own aging. I keep asking myself what am I going to be like in my elderly years." and "I know my mother has gotten old and it is scary. I was thinking how terrible it must be. I try to look ahead and I know that I am getting older, but I don't want to grow old."

Transition 4: Relationship Acceptance

The last transition involved a slow, realistic acceptance of the other—who she is, who she is not, strengths, limitations, the reality of what the mother/daughter relationship really is versus what was idealistically hoped for. Over time an acceptance naturally seemed to evolve where daughters and mothers have finally figured out the little idiosyncrasies of the other and neither is going to try to change them. As one daughter explained, "Yes, at this stage of our lives we are much more comfortable with one another." Some felt that their relationship was "time-limited" and it really wasn't worth trying to change. Both mothers and daughters reached a point where they recognized areas of conflict, but had stopped trying to rework these areas (Donorfio 1996). One daughter said, "I have made up my mind to not let the petty annoyances annoy me, with her in particular… things used to annoy me and I knew I couldn't fight it out with her so to speak. I can't do that with her." Another daughter added, "I guess we have both sort of adapted… I am not sure my expectations changed as much as going along with what is inevitable."

Being a part of the caregiving relationship gave mothers and daughters a chance to get to know the other in a different and more realistic way (Donorfio 1996). Many spoke of being more in tune with the other person's needs and feelings, leading to a new appreciation of the other. Many discovered a patience in themselves they never knew existed, helping them to become stronger, more compassionate and loving, and more open-minded. Lastly, mothers and daughters thought of lost dreams and how life would change when the mother passes.

Limitations

There are several methodological limitations inherent to this research. Due to the small and purposive nature of the sample, findings cannot represent other types of daughter/mother caregiving relationships (e.g., mothers with cognitive impairment, long distance caregiving, women of other cohorts) or other types of family, gender-mixed caregiving relationships (e.g., sons providing care to mothers, daughters providing care to fathers). The framework identified here could certainly be gender specific. Also, there is the possibility that mothers and daughters in better relationships were more likely to volunteer and the proportion of conflicted dyads underestimated. While the sample size is small and purposive, Reinharz and Rowles (1988) remind us, "In qualitative studies it is more likely that a small purposive sample be drawn. A purposive sample seeks cases that represent specific 'types' of a given phenomenon. The resulting sample allows the investigator to study the range of types rather than determine their distribution or frequency" (p.8).

Despite the limitations of the study design, the research has uncovered and deconstructed elements of filial responsibility and the mother/daughter caregiving relationship. Additionally, present findings bear remarkable similarity to those from other research (Boland and Sims 1996; Bowers 1987; Montgomery and Kosloski 2000; Nolan et al. 1985; Pfeiffer 1999; Shyu 2000). Additional research is needed to test the applicability of the framework to different family and gender compositions, and different racial and ethnic backgrounds.

Conclusions

Grounded theory pursues as its goal a theoretical understanding of a phenomenon founded in the experiences of the participants (Strauss and Corbin 1990). Rather than imposing theory on data, the data informs and shapes the theory. The results of this research uncovered a grounded theory framework of four intrapsychic transitions involved in providing and receiving informal care. The framework provides support that caregiving is a complex process that reflects the "cognitive, affective, motivational, and interpersonal components that mothers and daughters employ to 'make sense' out of their caregiving relationship" (Sheehan and Donorfio 1999, p. 172).

While many caregiving studies have examined the relational dynamics of mothers and daughters, very few studies have explored the intrapsychic trajectories and adjustment patterns that both daughters and mothers go through when in a caregiving relationship (Harding and Higgenson 2003). Filial responsibility seems to be a process that plays itself out in caregiving relationships by incorporating personal, parental, family, and religious influencing factors. Caring for a family member involves occupying a unique role and often times uncharted territory guided by family influence, social interactions, and explicit and implicit "rules" (Dimond and Jones 1983). Consistent with previous research (Guberman et al. 1992), daughters and mothers interviewed for this study provided a rich list of filial responsibility motivators such as: love, respect, guilt, power, obligation, responsibility, companionship, fear of being alone, living with oneself, feeling good, modeling for one's own children, inheritance and parental, family, and religious influences. Of all the motivators, participants saw personal influence as shaping the decision to care the most (Fingerman 2000; Josselson 1996; McGraw and Walker 2004).

A motivator that was not mentioned by the women in this research was social influence (Donorfio 1996). This coincides with the literature, which contends that while there were strong societal norms regulating parental deference in the 17th and 18th centuries, for the past two centuries, family roles have been nothing more than ambiguous (Blieszner and Hamon 1992; Cantor and Hirshorn 1989; Hareven 1995; Seelbach 1978; Selig et al. 1991).

Caregiving researchers and their developed frameworks illustrated in Table 1 are defined and constructed in many different ways. Some models consist of two stages; others up to six stages. Some researchers use the word "stage" to denote the practice of caregiving while others use the word "transition," "marker," "journey," "career," "phase," or "adaptation." Some look at one specific "period" in the caregiving trajectory such as institutional placement, dying and death, and bereavement. Others look at varying degrees of cognitive impairment and dementia. Despite the many differences inherent in each of the frameworks, when they are considered collectively, they all reveal that caregiving and the caregiving relationship is an ongoing "process over time." Findings from this research also support this. Mothers and daughters were trying to make sense out of their caregiving relationship and the different adjustments that accompanied it. Their emotional responses were overwhelming and complex. While they were trying to define their situation with some clarity, and many felt isolated. In addition, they had to redefine and expand their belief of what the roles were comprised of, realizing that caregiving and care-receiving involved much more than the physical; it also had emotional and conversational components (Donorfio 1996). As Boss (1993) affirms, caregivers and their families are less burdened by the severity of an illness than by the uncertainty it causes.

A finding grounded in the interviews was the participants' new found age awareness. For the first time, many of the women started to see and imagine themselves as growing and becoming older. For daughters, watching age-related decline in their mothers prompted "preservation strategies" or different ways they could safeguard their mothers' life by shielding them from any undue stressors (Allen and Walker 1992). Bassoff (1988) found that mid-life daughters are reluctant to consider even appropriate acts of filial negotiation or disagreement for fear it will emotionally destroy their weak or frail mothers. This could also be one explanation for the relationship acceptance that occurs between daughters and their mothers. Unlike Fingerman (1995) who found that aging parents tend to perceive greater compatibility between themselves and offspring than do offspring, this study does not support this, with mothers and daughters perceiving equal compatibility. Baruch et al. (1983) found that by middle adulthood daughters seem to develop a mature and objective view of their mothers. Bassoff (1988) further contends that daughters not only develop a realistic expectation of their mothers, but of themselves as well.

This research contributes to the literature in four significant ways. First it uses dyadic analysis and incorporates the feedback of both caregiving daughters and care-receiving mothers. Second, it is grounded in the "lived experiences" of the participants rather than being driven by the researcher. Third, it captures the intrapsychic processes involved. Lastly, this research provides a framework for understanding the interactions, ongoing processes, and transitions that occur in informal caregiving relationships of caregiving daughters and their care-receiving mothers.

Implications

This research has significant implications for researchers, therapists, caregiving support group leaders, and women (both caregiver and care-receiver) who are contemplating for being confronted with filial responsibility. As Lindgren (1993) supports, psychological frameworks of caregiving provide a structured way of organizing information on stage-specific needs, transitional needs, caregiving/receiving satisfactions, stress levels, and ways for coping. Grant et al. (2003) suggest that caregiving models are important because they are identifiable and predictable and could be of practical value to families as well as professionals. Other studies show that stages of caregiving provide a framework for major transitions and interactions that occur between caregiver and receiver and that an understanding of this process can help health care providers be more aware of the needs of families in different phases (Clark and Rakowski 1983; Sankar 1991; Shyu 2000; Burton et al. 2003).

There is minimal recognition that informal caregivers are usually novices in providing complex care and are, more often than not, unprepared for caregiving (Boland and Sims 1996). Findings from this research provide a framework for understanding the often unclear transitions that daughters and mothers believe they go through. The results also acknowledge that the caregiving relationship is a process that evolves over time, including past influences. This framework provides a vehicle to create and target caregivers for services that will most likely be effective for them depending on what transition they are currently undergoing (Montgomery and Kosloski 2000). For instance, interventions could be tailored for the entry into the caregiving relationship, including the roles and associated psychological tasks (Burton et al. 2003). Also, interventions could be shared with families at large to give them some insight on caregiving transitions to help understand the associated demands. As Hollis-Sawyer (2003, p. 20) brings to light, "We all walk this 'path' into later life, either as caregivers and/or the recipients of care, and the optimization of this experience is important for all concerned" (p. 20).

Appendix 1

Sample interview questions (Donorfio 1996)

- How would you describe your relationship with your mother/daughter?
- Do you enjoy time spent together? Explain.
- Do you feel close? Explain.
- Were you expected to care for your mother/Did you expect your daughter to care for you?
- Why do you provide the care you do? Explain.
- To what extent does obligation serve to motivate the care you provide your mother?
- What do you feel is a child's responsibility for their aging parents?
- What are the expectations of your children?
- Do you feel that your/your daughter's sense of responsibility has changed over time? Explain.
- If you/your daughter did not provide care, who would?
- In what areas do you and your daughter/mother have conflict? Explain.
- Do you and your mother/daughter agree as to the amount of help that should be given to her/you?
- What is this amount of help and how is it negotiated if differences occur?

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