Conflict in Families and Nursing Home Placement: A Phenomenological Study

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Conflict in Families and Nursing Home Placement:

A Phenomenological Study

by

Stephen John Pidwysocky

A Dissertation Presented to the Graduate School of Humanities and Social Sciences of Nova Southeastern University In Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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This dissertation was submitted by Stephen J. Pidwysocky under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment for the degree of Doctor of Philosophy in Conflict Analysis and Resolution at Nova Southeastern University.

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Dedication

For John P. McKendy, Ph.D. 1949-2008
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# Table of Contents

Abstract.......................................................................................................................................................... p. vii

Chapter 1 – Introduction................................................................................................................................. p. 1

Chapter 2 – Literature Review...................................................................................................................... p. 20

Chapter 3 – Methodology............................................................................................................................... p. 56

Chapter 4 – Data Analysis and Findings, Part I - Family History.............................................................. p. 82

Chapter 5 – Data Analysis and Findings, Part II - Siblings and Gendered Caregiving............................. p. 90

Chapter 6 – Data Analysis and Findings, Part III – Communication......................................................... p. 107

Chapter 7 – Data Analysis and Findings, Part IV – Reflections................................................................. p. 114

Chapter 8 – Discussion................................................................................................................................. p. 118

References..................................................................................................................................................... p. 132

Appendix A – Recruitment Poster................................................................................................................ p. 182

Appendix B – Interview Guide...................................................................................................................... p. 183

Appendix C – STU Third Age Center Electronic Advertising.............................................................. p. 184

Appendix D – First Cycle Codes................................................................................................................... p. 185

Appendix E – Province of New/Nouveau Brunswick, Canada.............................................................. p. 186
Abstract

In the qualitative research about families who have placed a family member in a nursing home, conflict is identified as a significant problem. Situational caregiving factors leading up to, during, and after nursing home placement can be the source of considerable family conflict. Using a transcendental phenomenological approach, this research sought to answer: 1) How does conflict occur within families who have placed a family member in a nursing home? 2) How can we better understand conflict in families who have placed a family member in a nursing home? 3) What kind of conflict resolution practices and social policy measures can be put into place to actively assist families should they experience conflict as a result of nursing home placement?

Fifteen semi-structured interviews were conducted with adult women who live in central and northwestern New Brunswick, Canada and had experienced interpersonal conflict in their family prior to, during, and after placing a family member in a nursing home. The findings of this study can be explained through the application of developmental theory, life span theory, social psychological equity theory, intersectionality theory, and multi-level family conflict theory.

Key Words: Caregiving, Family Conflict, Nursing Home, Alternative long-term care, Informal Caregiving, Formal Caregiving, Communication, Mediation, Phenomenology, Qualitative Research, Developmental Theory, Life Span Theory, Social Psychological Equity Theory, Intersectionality Theory, Multi-Level Family Conflict Theory, Interviewing, and New Brunswick, Canada.
Chapter 1 – Introduction

Family Conflict Prior To, During, and After Nursing Home Placement

Beth is a sixty-two year old retired business person who was widowed ten years ago when her husband, Jack, died. She has two adult daughters one of whom is married and has a one year old son. Her mother, Betty, who is also a widow, is eighty-three and lives in a nursing home that is located in the same small community as Beth. Beth is Betty’s eldest child. Betty also has a younger daughter, Paula, and a still younger son, Mike. Paula is single, works as the director of an animal shelter, and lives in a middle sized city two hours away from Beth and her mother. Mike is married and has two children eight and ten. He is a high school teacher and lives in another province that is an eight hour drive away from where Beth and his mother live.

Betty’s move to the nursing home was in part necessitated as a result of debilitating arthritis that makes it difficult for her to walk and advanced spinal stenosis which has resulted in severe curvature of her spine. However, what ultimately led to Betty’s move to the nursing home was her falling one morning in her bathroom and breaking her left hip while she was still living in her own home. After surgery to repair her hip, Betty’s family physician met with Betty and Beth – both Paula and Mike said that they could not attend the family meeting – and she strongly recommended that Betty move into a nursing home where she would receive constant care.

In spite of the fact that Beth has repeatedly asked and even pleaded with both her sister and her brother to assist her in caring for their mother, Paula and Mike have refused to participate. Their refusal to participate initially began when their mother was still living in her own home. A few years ago, when their mother began experiencing some physical challenges,
Beth was the first to respond. She started visiting Betty on a daily basis and coordinated in-home medical care and homemaker assistance for her mother.

With her mother’s move to a nursing home, Beth continues to be her mother’s sole primary caregiver outside of the nursing home staff. Not only did she apply for nursing home placement on behalf of her mother, she visited the few nursing homes that are located in her community and consulted with her mother before choosing the nursing home that her mother would eventually move into when a space there became available. Her siblings criticized her and argued with her. They said that even though they did not have any time to participate in the decision-making process, they would not have selected the nursing home that she and their mother eventually ended-up selecting. Angrily, they both said that they had heard from long-time friends who also live in the same community as Beth and Betty that the nursing home that Betty moved into was dark, depressing, and that it smelled musty.

Betty has lived in the nursing home for a little over two years now. She says that she likes where she lives. Beth’s sister and brother do not visit their mother on a regular basis. They say that between working and living their own lives, they simply do not have enough time to go and visit Betty. They do telephone her, but only every now and then. When they telephone Beth, they tell her that she has always been their mother’s favorite child and so they do not really understand why they should visit their mother except on Betty’s birthday and during holidays. They also say that they do not have enough money to get to the nursing home because it is too far away from where they both live.

This situation has contributed to increased hostility, anger, and conflict between Beth and her siblings. Betty is aware that her adult children are in conflict with one another and that they do not really speak with one another unless they absolutely have to, but because of her poor
health she is unable to intervene as she once used to when she was younger and her children were growing up.

Beth believes that her sister and brother should visit their mother much more often than they do. She does not understand why they do not participate as this is simply something that she does without any excuses or hesitation. She believes that in the same way that her mother took care of her when she was young, it is now her turn to take care of her mother now that Betty is old.

Aging

What goes on inside isn’t ever the same as what goes on outside.

Margaret Laurence
1926-1987
Canadian novelist and short story writer

The decision to move an older family member to a nursing home can be a difficult one for families. Research indicates that “The size, quality and proximity of people’s social networks are arguably among the things that determine whether seniors receive formal care delivered by professionals …” (Cranswick & Thomas, 2005, p.10). Early qualitative research in the area of nursing home placement discussed how the French (Ross, 1977) and Jewish cultures (Holzberg, 1982; Hendel-Sebestyen, 1979; Myeroff, 1978) viewed this particular aspect of aging. Somewhat later, research studied how residents responded to nursing home living (Stafford, 2003; Gubrium, 1997; Gubrium, 1993; Diamond, 1992; Gubrium, 1991). More recent research has been critical of the traditional nursing home model. This research argues that nursing homes are too “hospital-like” (Erber, 2005, p. 400) and should therefore be seen as
outdated and in need of immediate restructuring. Following this line of argument, some families admonish the traditional medical nursing model of providing for long-term care and state that it exerts an uncaring attitude towards residents (Kane & West, 2005). Other families, as a result of limited choice in long-term formal caregiving options, work with this model as they believe that this is the only way that they can best care for their family member (Rowles & High, 2003). Both criticisms of the medical nursing home model and the push towards developing alternative nursing home options have encouraged the creation and implementation of more resident-driven inclusive nursing home models such as the Eden Alternative, Pioneer Network, and Green House concept of care (Hooyman & Kiyak, 2010).

As some aging families are faced with the need to place older family members in nursing homes, some of whom may have not experienced what it is like to move a family member into a nursing home ever before, there is a risk that some families may experience interpersonal conflict (Connidis, 2010; Matthews, 2002). In their discussion about interpersonal conflict, Katz et al. (2011) state that “conflict is an exposed struggle in which two or more interdependent parties are experiencing strong emotion resulting from a perceived difference in needs or values” (p. 81). For Canary & Canary (2013), conflict, as it impacts upon the family, “…refers to incompatibilities that can be expressed by people related through biological, legal, or equivalent ties” (p. 6).

In this qualitative study, I focus on the interpersonal conflict and discord that has occurred in families in relation to caregiving prior to, during, and after having placed a family member in a nursing home. As initially argued by White & Klein (2008), I too believe that
Because conflict is both endemic and inevitable, the primary concern in the study of social groups such as the family is how they manage conflict. Harmony is an achieved rather than a natural state. (p. 184)

A significant component of my research in the area of nursing home placement and conflict in families focuses in on sibling relationships. In his discussion on sibling relationships, McPherson states that “Siblings represent a long-lasting family bond with a shared…cultural heritage from early childhood to death” (2004, p. 252). The family relationships that developed when siblings were young often extend into adulthood. Connidis’ (2010) research supports this argument. She states that

Continuity is a central element of relationships in later life. Most relationships in older age are continuations of those begun earlier in life, and their nature is shaped by past patterns. Poor relationships will probably not become good ones simply because one reaches old age, and good ones are unlikely to remain that way. (p. 5)

My research demonstrates that past sibling relationships impact on the kind of caregiving that adult children provide for their older parent(s). This is significant as increased demand for nursing home care, generated by aging baby boomers (Hershey & Henkens, 2013; Business Wire, 2010; Cox, 2006), will inevitably place some families in conflict situations. Research on baby boomers argues that

It is important to recognize that the baby boom cohorts will age in a society that is older, more populous, and more diverse than previous cohorts, and that the challenges posed by their aging will vary over time. It is also important to acknowledge that since we are talking about the future, there is great uncertainty
about the conditions and statuses baby boomers will experience … as they move through the later stages of their lives. (Cornman & Kingston, 1996, p.17)

Utilizing a modified transcendental phenomenological approach (Cooper, 2010; Lindseth & Norberg, 2004; Pollio et al., 1997), I seek to understand the lived experiences (Porter & Cohen, 2012; Moustakas, 1994) of fifteen women interviewed between December 2012 and April 2013, who live in the central and northwestern regions of New Brunswick, Canada. I am keenly interested in learning about interpersonal family conflict prior to, during, and after nursing home placement as the number of older individuals in industrialized countries like Canada and the United States is said to be something that will continue to increase for several decades (Stassen-Armstrong & Templer, 2005).

In the United States, “demographers predict that the elderly population will reach 71 million, or 20% of the total population, by 2030” (Byrne et al., 2009, p. 1205). In a recent American census study, “the U.S. Bureau of the Census predicts that by the middle of the next century the proportions of young persons and elderly will be almost equal, the young constituting 23 percent of the population and the elderly 22 percent…” (Cox, 2006, p. 4). Checkovich & Stern argue “increases in the level of impairment faced by the elderly precipitate increased demand for long-term care” (2002, pp. 441-442).

As in the United States, in Canada there is a similar aging of the general population trend. It is said that

Nearly five million seniors live in Canada, comprising nearly 15 per cent of the population. And those numbers are growing quickly as the bulk of the baby boom generation hit their 60s. (Hildebrandt, 2013, p.1)
A recent national survey indicates that “…by 2056 the proportion of Canadians 65 years and older will more than double to over 1 in 4; the proportion of older seniors 80 years and over will triple to about 1 in 10, compared with about 1 in 30 in 2005” (Cranswick & Dosman, 2008, p. 49). In another study, it is stated that

As of July 1, 2010, there were 1,333,800 people aged 80 years and over in Canada, representing 3.9% of the total population. The number of people aged 80 years and over could double by the year 2031 and by 2061 – the end of the projected period of the most recent projections – there could be 5.1 million people in this age range.

(Milan, 2011, p. 2)

In the eastern region of Canada - where the Province of New Brunswick is located - a recent Canadian demographic report indicates that there exists

An East-West divide in the relative age of census metropolitan areas: the younger census metropolitan areas were mostly in Western Canada, while the census metropolitan areas with older populations were generally in the eastern part of the country. (Charbonneau et al., 2011, p. 2)

In 2011-2012, in New Brunswick, there were 4,312 individuals who were living in a nursing home. Of these nursing home residents, 3,900 were seniors (Doucet, 2012, p.30). This number will only continue to increase as the population of aging baby boomer New Brunswicker’s continues to grow.

In a Canadian General Social Survey published in 2012, it was noted that “Longer life expectancies and the transition of baby boomers into their senior years have meant that more Canadians may require assistance and care related to aging, now and into the future” (Sinha, 2013, p. 4). The aging of the baby boomer population demands that we develop pro-active
public policy in connection with nursing home care. As Cornman & Kingston argue “…an open public discussion needs to clarify the various values, implicit and explicit, at stake in choices for the aging society” (1996, pp. 23-24). Of course, the choices that are defined as important will then impact on caregivers.

The responsibilities associated with being a caregiver are challenging (Matthews, 2002). It is argued that in Canada, “The role of caregivers, such as family members and friends, has become increasingly important, particularly with the changing age structure of Canadian society” (Sinha, 2013, p.4). For some individuals, caregiving is seen “…as the most significant, ennobling endeavor that they’ve ever undertaken” (Jacobs, 2006, p. 15). For other individuals, caregiving is defined as a burden (Erber, 2005; Hinrichsen & Dick-Siskin, 2000).

American and the Canadian Nursing Home Care

In the United States, long-term nursing home care is the responsibility of both the federal and state governments (Hooyman & Kiyak, 2010). The way that the system operates,

Most nursing facility care is paid for by Medicaid, a combined federal and state program, although some benefits are paid for by Medicare, Veteran’s Affairs, and private pay (Johnson & Bibbo, 2014). Private long-term care insurance policies are being encouraged to be purchased to decrease government costs as the population increases in number and longevity. (Hogstel, 2001, p. 406)

A problem with this is that under Medicaid there is little uniformity in nursing home care from state to state. Under Medicaid, “…federal funds are administered by each state, which results in considerable variation in the quality and quantity of services provided” (Hooyman & Kiyak, 2008, p. 735). A second problem is that “Most nursing homes (about 65 percent) are
proprietary or for-profit, and thus operate as a business that aims to make a profit for the owners or investors” (Hooyman & Kiyak, 2010, p. 446).

In Canada,

The Canada Health Act of 1984, the basis of Canada’s health care system, ensures hospital and physician care for all Canadians. One important benefit of the system is that it protects acute and chronically ill older people from financial ruin in case of a long-term illness. (Novak & Campbell, 2006, p. 172)

A critical way that this happens is that “The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer” (Health Canada/Santé Canada, 2011, p. 3). However, in the case of nursing homes, “Older people who need other types of long-term care, … must often turn to the social welfare system for help” (Novak & Campbell, 2006, p. 172).

In her research on long-term care in Canada, Canadian academic, the late Betty Havens (1995), argued that “…community-based long-term care is both less universal and less uniform across the country than any other form of health care” (p. 84). The problem of universal access and lack of uniformity is a direct result of the fact that “In Canada, health care is the responsibility of the provinces and territories…” (Cooke et al., 2012). As a result of minimal federal government funding (Havens & Bray, 1996), increasingly for-profit nursing homes have been established. Based on data that was collected in 2001, research shows that “In the Atlantic provinces, for-profits dominate, accounting for 40 percent of long-term care beds” (Armstrong et al., 2009, p. 36). The remainder of nursing homes in Atlantic Canada were run by: government = 22 percent, not-for-profit = 28 percent, and religious = 10 percent (Berta et al., 2006). Generally speaking, although the health care systems of the United States and Canada
are distinct from each another, that distinctiveness narrows down considerably when it comes to how nursing homes operate. Nursing homes in these two countries follow a similar funding scheme unlike, for example, nursing homes in Norway where “Most Norwegian nursing homes are publicly funded and operated by Norwegian municipal authorities” (Gjerberg et al., p. 633).

General Issues that Resonate with Everyone – Private Family Matter, Family Structure, Caregiving Demands and Stress, Lack of Preparation and Poor Interpersonal

In their research on siblings caring for older parents, Tolkacheva et al. (2014) argue that “…there is a limited systematic research that takes into account caregiving by all living siblings and investigates which families are most likely to share the care among siblings” (p. 314). My research about conflict in families and nursing home placement therefore addresses a very specific type of conflict. In the research about families and conflict, it has been argued that family conflict is something that occurs quite frequently (Sillars et al., 2004; Shantz & Hartup, 1992; Shantz & Hobart, 1989). In their research, Krause & Rook (2003) note “…that negative interaction is more likely to be encountered with family than with friends” (p. 391). Their research is supported by Morgan’s (1989) study which also found that on the whole families experienced greater negative interpersonal interaction than other social relationships. When older families experience negative interpersonal interaction, family conflict is inevitable (Fingerman, 2001; Johnson & Catalano 1983). As it impacts on caregiving, Clarke et al. (1999) argue that …conflict and its relational effects may lessen the willingness to participate in caregiving and to limit the frequency of duration of the support provided to failing parent. (p. 268)

Additionally, because family conflict is usually seen as private, it is not discussed with non-family members (McPherson, 2004). To reveal private family information outside of the
family is seen “… as a betrayal of the family established rules prohibiting the disclosure” (Caughlin et al., 2013, p. 321). In his early research in the area of family relationships, American sociologist, Reuben Hill (1958), argued that the “…family performs like a closed corporation in presenting a common front of solidarity to the world, handling internal differences in private …” (p. 222). Similar to Hill’s argument, in their research, Canadian sociologist, Anne Martin-Matthews, and Canadian gerontologist, Janice Keefe (1995), state that “In Canadian society, the care of elderly kin is largely perceived as a private trouble to be managed within the invisible realm of the family” (p. 116). Caughlin et al. (2013), argue that a key reason why families attempt to keep some information private is because it contributes to increased bonding and trust among family members. Tannen (2001) presents a similar argument when she says that “Secrets kept within the family reinforce the fortress walls, aligning family members with each other” (p. 39). In part because of issues having to do with bonding and trust, family conflict is often left to fester and escalate in an atmosphere of isolation. In turn, this contributes to an increase in intensity (Strauss, 1990) of conflict as experienced by family members. As evident in my data, many of the family conflicts linked with caregiving and eventual nursing home placement occurred because of pre-existing unresolved private family conflicts.

**Family Structure**

Before discussing family caregiving and conflict prior to, during, and after nursing home placement it is important that I first define what a family is. There are many definitions of what constitutes a family. I prefer the definition presented by Turner and West (2006) as it is inclusive of the many family types that now exist in Western society. They state that “a family is a self-defined group of intimates who create and maintain themselves through their own interactions and their interactions with others” (p. 9). In their discussion on the family unit,
Koerner & Fitzpatrick (2006) argue that there are four different types of families. These four types are influenced by two factors. “The first is conversational orientation, or the extent to which families have open discussions about attitudes, feelings, values, and so forth. The second, conformity orientation, concerns how family climates promote homogeneity in beliefs” (Canary & Canary, 2013, p. 6). Based on these two factors, the four types of families are: consensual families (high in both conversation and conformity), pluralistic (high in conversation but low in conformity), protective (low in conversation but high in conformity), and laissez-faire (low conversation and low conformity) (Canary & Canary, 2013). The data that I gathered by interviewing, is most closely representative of the protective and laissez-faire family models where there is low conversation and varying levels of conformity.

Caregiving Demands and Stress

Be it poor health (Brandt et al., 2009; Igel et al., 2009; Dautzenberg et al., 2000) or old age (Pezzin et al., 2008; Byrne et al., 2002; Stern, 2002) research indicates that “…children are motivated by love for their parents so that their provision of care is driven foremost by parents’ needs” (Szinovacz & Davey, 2013, p. 668). We have long since established that “caregiving … takes place within the context of family or close social relationships” (Ross-Sheriff & Swigonski, 2009, p. 222). Caregiving founded in love and provided by family members or close friends, however, can be very demanding and as such it can have serious physical and/or psychological impacts on the well-being of the caregiver(s) (Given et al., 2012; Whitebird et al., 2012; Scharlach et al., 2006; Pinquart & Sörenson, 2003; Dwyer et al., 1994) and in extreme cases may even contribute to caregiver death (Perkins et al., 2013). Boelk & Kramer (2012) argue that “Few Families are perfectly cohesive, and under stress of illness, hidden tensions may easily erupt” (p. 656). Stress can trigger family conflict as it is “… both an adverse external
circumstance and the extent to which the circumstance poses a challenge to the organism’s response mechanisms” (Bugental, 2012, p. 806).

In a research study by Li et al. (2013), caregivers were said to suffer with both primary stressors such as the actual illness of the family member in need of care and secondary stressors like inability to sleep, the challenges of balancing caregiving and employment, and caregiving and maintaining other interpersonal relationships. Their study indicated that

Overall, female spousal caregivers were affected by receiving less social support, providing more emotional support and having a disrupted schedule. Male spousal caregivers were affected by their lack of preparedness for the caregiving role, thus suffering from loss of sleep/fatigue and difficulties in expressing their emotions.

(p. 184)

For adult children caregivers, Strauss (2013) reported that caregivers experienced “…significantly higher levels of family strain, and appeared to be more vulnerable to the effects of strain…” (p. 61). In spite of this, families who possess a strong group identity (Maguire, 2012) are said to be more than capable of addressing stress and strain when they occur.

Lack of Preparation and Poor Interpersonal Communication

In her research about aging, Sarah Matthews (2002) argues that Siblings typically have very little practice in dividing family labor before their parents get old. When they reach adulthood, they usually move out of their family of origin literally and figuratively. Their relationships with one another continue, but they have no reason to work together to solve problems. (p. 202)

As children become their older parents’ caregivers, they are faced with new demands. In her research, Patterson (1998) states that
A family demand is defined as a stimulus or condition that produces or calls for change in the family system. Because change is implied, a demand can be viewed as a threat or a challenge to the family’s existing homeostatic functioning. (p. 210)

Demands are themselves influenced by such factors as culture, gender, social economic status – including the need for caregivers to retain employment – sibling age order, family structure, and family history, (Gilligan et al., 2013; Conidis, 2010; van der Pas & van Tilburg, 2010; Lublin, 2009; Mollica, 2009; Bolin et al., 2008; Davey & Szinovacz, 2008; Pavalko et al., 2008; Wolff & Kasper, 2006; Martire & Stephens, 2003; Merrill, 1997; Davidhizar, 1992). In addition to these factors, families experience situations where family members disagree because their individual “…expectations are opposing or incompatible” (Kramer et al., 2006, p. 794). The research participants that I interviewed shed light on how conflict occurred in their own families in connection with caregiving and nursing home placement and how, or if, it was addressed.

What happens when caregiving has to take place outside of the family, shifting from a private setting to a public institutional setting? How is the decision to move from private to public made and who makes this decision? What are the conflicts that might possibly arise in families when the decision to move a family member to a nursing home is made? Dellasega et al. (1995) found that “despite the fact that family members had experience in providing substantial levels of supportive care for their elder in the months immediately preceding the placement, none has seriously considered the need for formal care in the future” (p. 130). In a similar finding, Roff et al. (2007) state that in their phenomenological study,

The majority of participants said that they had not talked with siblings and parents about a formal care plan. They described informal discussions that led to no clear resolution and improvisation strategies…. Typically they expressed a nagging sense
that the need for open discussion was imminent, but they did not appear to be psychologically ready to develop an explicit plan. (p. 320)

Given et al. (2002) state that

Family members are seldom prepared to be caregivers … They become caregivers immediately at the point of diagnosis and continue in this role over the disease, treatment, and survivorship trajectory. (p. 58)

In their research on how families can best prepare for caregiving, Fowler and Fisher (2009) state that there are three basic steps that families should follow. They argue that

The first is becoming aware of parental care needs, which involves recognizing, considering, and monitoring parental vulnerabilities.
The second is the gathering of information about possible needs, preferences, or options for care. The third is the level of parent-child discussion individuals report about caregiving arrangements.

(p. 620)

Like Fowler & Fisher, Russell (2010) argues that what families must do more of is talk regularly and if it is possible to have more frequent contact. Thorough interpersonal communication thus becomes a critical component in preventing interpersonal family conflict.

Katz et al. (2011) argue that communication serves as a significant way of preventing interpersonal conflict as “People use language as a way to represent their experience to another” (p. 1).
Specific Healthcare Issues in Canada and in New Brunswick

Throughout Canada, including New Brunswick, funding to long-term formal care has been reduced (Connidis, 2010; Chappell & Penning, 2005). Research indicates that “While some seniors have greater incomes than previous years, those who are most likely to require public long-term residential care are least likely to have the means to pay for it” (Shapiro & Seeley, 2009, p. 59). As discussed earlier, the reduction in government funding has contributed to the rise in for-profit nursing homes which is significantly higher in the Atlantic Provinces than in other parts of Canada (Berta et al., 2006). Decreased government funding has placed increased financial responsibility on caregiving families. In New Brunswick, following provincial regulatory nursing home policy, nursing homes must “collect from the client the amount of financial resources indicated on the notification of financial subsidy, consistent with Social Development Standard Family Contribution” (Doucette & Balani-Poirier, 2012, p. 6).

As calculated by Statistics Canada in 2012, “By 2030, no age cohort will dominate. That means New Brunswick residents over the age 65 and those under the age of 14 will combine to outnumber working adults” (McLaughlin, 2012, p. 8). When combined, these three factors, reduced government funding, a corresponding lack of resources, and an aging population, will place additional strain on both nursing homes and on families.

Available Resources

In their early research on aging families, Johnson & Bursk (1977) stated that “Familial ties between elderly parents and their adult children cannot be regarded in isolation but are part of the total pattern of aging in our society” (p. 90). Thirty-Seven years later, there is some doubt whether American and Canadian societies have truly accepted this idea. Certainly, on the basis of available government allocated financial resources that both nursing homes and families
receive, financial resources that are simply not there, suggests that older families will continue to be isolated by society. To address this situation families must begin planning for possible nursing home care well before it is needed (Bromley & Blieszner, 2012). In addition to this step, adult children, if they are able, might consider sharing their finances when caregiving for their older parents (Swartz, 2011). In other families where geographical proximity (Pillemer & Suitor, 2006; Roff et al., 2007; Stern, 1995) is a challenge and either some or all adult children live in areas that are distant from the community that is home for their older parents, community-based services should be developed that promote frequent social contact with non-familial caregivers. Finally, a resource that can be improved on is interpersonal communication (Wittenberg-Lyles et al., 2012). Encouraging increased communication prior to, during, and after nursing home placement can reduce interpersonal conflict.

Chapter One Summary

I have introduced seven additional chapters to assist readers when reading this study. I have briefly introduced family conflict and nursing home placement in Chapter One. In Chapter Two, I discuss the history of the nursing home and outline three contemporary nursing home models that are transforming the traditional model for nursing home care. I then explain the difference between informal and indirect caregiving and formal direct caregiving. Next I discuss how conflict in families and nursing home placement can in part be explained by family structure – number of siblings, gender(s) of siblings, and geographical distance between adult siblings and older parent(s). Finally, I introduce six contemporary theories as a way of understanding how interpersonal conflict in families occurs prior to, during, and after nursing home placement. The theories I appeal to are: interpersonal conflict theory, developmental theory, life span theory,
social psychological equity theory, intersectionality theory, and multi-level family conflict theory.

In Chapter Three, I discuss the research methodology used in my study. I employed qualitative transcendental phenomenological semi-structured interviews to learn about the conflict experiences that my research participants had lived through as a result of placing an older parent in a nursing home. In this chapter, I discuss qualitative research, transcendental phenomenology, ethical issues when conducting research with human research participants, the framework of semi-structured interviews, how I recruited research participants, interviewing and transcribing interview data, the process of coding interview data, and the significance of creating an audit trail as a way of ensuring the rigor of qualitative data and data analysis.

Chapters Four through Seven – data and findings - are based on my interview data. I begin by discussing how family history can contribute to conflict in families and nursing home placement. I then discuss conflict between siblings and the gendered nature of caregiving and conflict. Chapter Six focuses on poor interpersonal communication and increased conflict. The final data chapter, Chapter Seven, titled “reflections” I share my interview participants reflective thoughts and ideas after having experienced this type of conflict.

In the concluding discussion chapter, Chapter Eight, I reflect on Chapters Two through Seven referencing material found in Chapter Two. I then discuss the limitations of the study. I raise three possible ways of addressing conflict in families as a result of nursing home placement. The three approaches that are discussed are introducing nursing home policy that promotes greater family involvement and communication with the process of moving a family member to a nursing home, facilitating enhanced interpersonal communication between family members through the involvement of a third party such as a family mediator, and encouraging
government to consider newer models of long-term care in place of the older medical nursing home model. I conclude the discussion chapter in my study with suggested areas for future research.
Chapter 2 - Literature Review

In this chapter, I will discuss the establishment of nursing homes in the United States and Canada, outline three progressive contemporary models for nursing home living, introduce the concept of filial responsibility, underscore the distinction between informal and formal caregiving, continue my discussion on families and family conflict and nursing home placement, apply interpersonal conflict theory, developmental theory, life span theory, social psychological equity theory, intersectionality theory, and the multilevel model of family conflict as viable theoretical ways to understand this type of family conflict, and discuss the process of moving into a nursing home in the Province of New Brunswick.

Nursing Homes

The development of nursing homes “is a twentieth-century phenomenon” (Braithwaite, 1993, p. 18). It has been argued that “in the early 1900s, for example, objective presence of family ties was absolutely essential for the aged. In the case of infirm elderly, family life provided the only basis for care with the grim exception of the poorhouse” (Snider, 1981, p. 326). In the United States and Canada, the establishment of nursing homes has followed a parallel track. In both countries, almshouses or “poorhouses” preceded nursing homes (Davies, 2001), which were privately and publicly run facilities used for the placement of marginalized individuals, including the elderly, impoverished, disabled, mentally insane, prostitutes and children who had been born into the almshouse (Schell, 1993). As a result of insufficient funding and mistreatment, care in poorhouses was often inconsistent and neglectful (Schulz, 2006; Lacey, 1999).

In the United States, the “system of letting the support of the poor out to the lowest bidder on an annual basis was common in Massachusetts and other parts of New England in the
seventeenth and eighteenth centuries, especially before the erection of almshouses became widespread, and was prevalent in New Brunswick during the nineteenth century” (Whalen, 1972, p. 54). From

… the 1930s through to the 1950s, … there was a great growth in the interest in old age. Over these decades, pushed by public pressure and new professional concerns, efforts were made to sever the historical link between the old age home and the poorhouse and to reshape residential accommodation for the aged into middle-class medical institutions. (Davis, 2001, p. 156)

The introduction of the Social Security Act in 1932 (Lacey, 1999), facilitated the establishment of privately run for profit nursing homes (Fernandes & Spencer, 2010; Binstock & George, 2006; Lassey & Lassey, 2001; Baum, 1999; Diamond, 1992) and publicly run government subsidized nursing homes (Gubrium, 1997) in the United States. Beginning in 1965, “Medicaid and Medicare shifted the center of decision making about funding and standard setting to the federal government, but responsibility for program delivery and regulatory implementation remained with the states” (Braithwaite, 1993, p. 21).

In Canada, although the Canada Health Act regulates national health care, nursing homes are largely regulated by individual provinces and territories (Stadnyk, 2002; Greb et al., 1994) and as such vary significantly in the care provided to senior citizens. Some provinces, such as British Columbia (Davis, 2001) and Ontario have considerably more resources (Fernandes & Spencer, 2010) than the Maritime provinces – New Brunswick, Nova Scotia, and Prince Edward Island (Stadnyk, 2002) provinces that historically have much less in terms of resources to devote to senior care. Regardless of country of operation and governmental involvement, nursing
homes are generally based on a structure where residents are supposed to receive constant medical care (www.oecd.org/health/longtermcare, 2011).

Like the United States, Canada is a geographically large country (http://www.yourcanada.ca/geography/). In 2011, the population was 34,278,400 smaller than the total population in 2011 of 37,253,956 for the State of California (http://quickfacts.census.gov/qfd/states/06000.html). During the last Canadian general census persons who recorded their age as 65 years or older comprised 13.7% of the population ((http://www.statcan.gc.ca/daily-quotidien/070717/dq07071a-eng.htm). One in every seven Canadians is now considered to be a senior citizen (http://www.statcan.gc.ca/daily-quotidien/070717/dq07071a-eng.htm). Nationally, the proportion of older individuals in Canada is higher than it has ever been (http://www.cbc.ca/news/canada/story/2012/05/29/census-data-release.html). In New Brunswick, it is forecasted that “the province’s population will age faster than the rest of Canada” (McLaughlin, 2012, p. 8). Four factors are said to be contributing to this aging shift. They are: the aging of the baby boomer generation – individuals who were born between 1947-1966, declining birth rates, young people leaving the province in search of work in central and western Canada, and longer life expectancies (McCloughlin, 2012).

Contemporary Nursing Homes

20th Century engineered nursing homes are “… the most costly form of supportive living environment” (Erber, 2005, p. 401). They have also been very different from their historical counterparts, because of the increased attention to all aspects of caregiving – physical and/or psychological (Thomas, 1996). Regardless of whether nursing homes are private for-profit,
government not-for-profit, or denominational run, the practice of caregiving that has historically been followed in these nursing homes is a medical one (Ragsdale & McDougall, 2008). Under this model, “…nursing home care has historically been provided to accommodate regulatory requirements without consideration of meeting the resident’s individual needs” (2008, p. 993). Aging baby boomers have been very vocal when it comes to long-term care (Robison et al. 2014; Blumenstock, 2006).

Contemporary nursing homes are revising the type of care they provide, giving residents a greater say in how the facility where they live operates (Schulz, 2006). Research on nursing home resident inclusivity shows that “The feeling of being in control of one’s life appears not only important for restoring personal dignity, but has elsewhere been mentioned as contributing to becoming satisfied with living in a long-term care facility over time” (Oosterveld-Vlug et al., 2013, p. 6). Research argues that self-control for nursing residents facilitates happiness (Coughlin et al., 2000; Flemmer, 1995; Banziger & Roush, 1983). Increasingly, nursing homes are actively encouraging more resident-centered care (Hartmann et al., 2013; Hooyman & Kiyak, 2010). Resident-centered care supports the idea of “…deinstitutionalizing services and individualizing care” (Miller et al. 2010, p. 66S). The Eden Alternative, Pioneer Network, and the Green House nursing homes are three innovative, contemporary models emerging, in part, because of changing ideologies regarding nursing home care (Hooyman & Kiyak, 2010; Thomas, 1996).

The Eden Alternative model emphasis is placed on improving the quality of life for residents (LaValley, 2010). Initially established in Australia (Brownie, 2010) this model rejects the medical model as the basis for nursing home care and addresses the “…three nursing home plagues: loneliness, helplessness and boredom” (Weinstein, 1998, p. 3). Nursing home residents
are invited to participate in activities such as gardening, pet therapy, and they are encouraged to interact with children when children visit the nursing home (Tavormina, 1999). It is argued that the Eden Alternative nursing home model is superior to the traditional nursing home model because it is believed that “Control over some part of their environment, if they are capable, will most likely enhance nursing home residents’ quality of life” (Erber, 2005, p. 402).

Like the Eden Alternative model, the Pioneer Network for nursing home care stresses the need to change the culture of ageing. The medical model is therefore replaced with a nursing home community model where residents choose what recreational activities they will participate in as well as what their daily routine will look like (Fagan, 2003). In addition to promoting resident-centered living, the Pioneer Network encourages the benefits of empowering front-line staff by “… supporting core systems (such as breaking down departmental hierarchies, creating flexible job descriptions, and giving front-line workers more control over work environments)” (Koren, 2010, p. 2). Under the Pioneer Network staff empowerment model, “It is reasoned that certified nurses aids (CNAs) have the most knowledge about nursing home residents” (Yeatts & Cready, 2007, p. 324). Because of this, nurses aids should have a greater say as to what kind of care residents will benefit from.

In the Green House model, the traditional nursing home building is replaced with a series of smaller residence homes that offer both private accommodations and public common gathering areas (Ragsdale & McDougall, 2008). In Green House homes, “Physical space is designed as a home – large great room with fireplace, communal dining table, and walk-in kitchen open to dining room and great room” (Sharkey et al., 2011, p. 126). Both residents and their families have responded positively to the “small-house model” that is central to the Green House home approach to caregiving (Lum et al., 2009). “Studies show that residents are happier
and stay healthier longer” (Jaffe, 2013, p. 2). In the United States, as of mid-2013, there were “…148 Green House homes” (Jaffe, 2013, p. 1).

Nursing Homes and Families

In one definition about caregiving for older parents, caregiving is defined as a situation where “in broad terms, adult children … provide emotional support for the aging parent, tangible assistance in the form of unpaid labor, and financial assistance” (Strauss, 2013, p. 52). A critical concept linked to caring for older parents is filial responsibility – meaning adult children caregiving for their older parents (Silverstein & Giarrusso, 2010; de Valk & Schans, 2008; Gans & Silverstein, 2006; Ganong & Coleman, 2005; Fingerman et al., 2004; Killian & Ganong, 2002; Dwyer et al., 1992; Matthews & Tarler-Rosner, 1988; Brody, 1985). A type of reciprocity, adult children become caregivers as their parents once took care of them (Gans & Silverstein, 2006; Dwyer, Lee, & Jankowski, 1994).

Filial Responsibility and the Gendered Nature of Caregiving

Filial responsibility is said to be multidimensional in that it is made up of “…societal, familial, attitudinal, and psychological dimensions” (Donorfino & Sheehan, 2001). Initially introduced into social work theory in 1965 by Margaret Blenker, Blenker stated that “…filial maturity [was] … part of the developmental sequence…” (Shanas & Streib, 1965, p. 57). She argued that

…the filial crisis may be conceived to occur in most individuals in their forties or fifties, when the individual’s parents can no longer be looked to as a rock of support in times of emotional trouble or economic stress but may themselves need their offspring’s comfort and support. (p. 57)
Filial responsibility was identified as a critical factor among older adults by Blieszner & Mancini (1987) who “… found that the respondents had much higher expectations of support from family members than from either close or casual friends…” (p. 176). In addition, increases in filial responsibility occurred when families had planned and discussed what might happen in the future (Bromley and Blieszner, 1997). A sense of filial responsibility appears to be higher in black families than in white families (Anderson, 2009; Byrne et al., 2009; Harris, 2009; Pealer, 2008; Shuey & Hardy, 2003; Burr & Mutchler, 1999; Lee et al., 1998) and more important for women then for men (Gans & Silverstein, 2006; Matthews & Heidon, 1998, Stein et al., 1998; Finley et al., 1988).

Filial responsibility is absolutely gendered – in an overwhelming majority of circumstances, it is a responsibility assumed by women as opposed to men because women are seen as “the” nurturers (Connidis, 2010; Dwyer and Coward, 1992). Additionally, research shows that women are “… susceptible to feeling guilty when they do not conform to traditional gendered family roles” (Dayton-Ingersoll et al., 2003, p. 210). That women are the primary caregivers for older parents has been extensively documented (Pope, 2012; Gaugler et al., 2008; Williams & Crooks, 2008; Houser, 2007; Pillemer and Suitor, 2006; Wolff & Kasper, 2006; Shuey & Hardy, 2003; Browder, 2002; Checkovich & Stern, 2002; Engers & Stern, 2002; Marks et al., 2002; Stein et al., 1998; Bromley & Blieszner, 1997; Wolf et al., 1997; Mui, 1995; Aronson, 1992; Dwyer et al., 1992; Traustadóttir, 1991; Brody, 1985; Stoller, 1983).
Hequembourg & Brallier (2005) argue that women do the majority of filial caregiving because

…women spend more time providing care because they are responsible for the time-consuming tasks associated with primary and routine care, while men tend to provide secondary care or perform jobs that have clearly defined boundaries, are time-limited,…and have an element of discretion as to when they can be done …

(p. 55)

Horowitz (1985) argues that women’s “…traditional assumption of nurturing tasks, their stronger emotional tie to their family of orientation, and the fact that they have more flexible free time in their role as homemakers… facilitates caregiving” (p. 612). More recent research suggests that women “… experience more burden and psychological distress in caregiving role than men” (Marks et al., 2002, p. 657). Women assume the role of caregiver more often than men because they continue to be socialized to be nurturers (Dwyer & Seccombe, 1991) and also because many individuals continue to believe that women are responsible for home and family while men are responsible for non-domestic obligations (Thornton & Young-DeMarco, 2001). For never-married women, the pressure to act as caregivers may be even higher because they have no other immediate family obligations (Henz, 2006). Finally, Abel (1986) states that “the burdens of parental care typically fall on women in late middle age or early old age, just when their own health and energies may be waning” (p. 482).

Although women assume the role of caregiver in the majority of situations, some men do indeed act as caregivers (Davey & Szinovacz, 2008; Hequembourg & Brallier, 2005; Dentinger & Clarksberg, 2002; Kramer, 2000; Gaugler et al., 1999; Harris, 1998). In her study about men and caregiving, Harris (1998) states that there are four types of caregiving men: the dutiful son,
the son who goes the extra mile, the son who is the strategic planner, and the son who shares the care with other family members (pp. 348-349). The need for men/sons to actively engage with caregiving for an older family members is said to become much more of an issue in the coming years because of “…declining family size and increasing proportions of women entering the labor force” (Allen, 1994, p. S194).

Siblings

When discussing family structure and caregiving in older families, where there are a minimum of two adult children, it is prudent to first describe the sibling relationship. Research indicates that the sibling relationship is unique in five ways. The five ways are: the lengthy duration of the relationship (Ponzetti & James, 1997; Bedford, 1993), the permanent and involuntary nature of the relationship (Cicirelli, 1995), its similarity to a friendship relationship (Cicirelli, 1988), it is based on a shared family history (Brody, 1998; Stocker & McHale, 1992), and that it can be based on both love and animosity (Mikkelson, 2004; Rinaldi & Howe, 1998; Kahn, 1983). In a seminal study by Gold (1986), older sibling relationships were placed on a continuum and ranked on the basis of psychological feelings of closeness and life involvement. Gold found five types of sibling relationships. The five types of sibling relationships that he identified were: intimate (14%), congenial (30%), loyal (34%), apathetic (11%), and hostile (11%) (p. 289).

In a more recent study on emotions and the family, Fosco & Grych (2013) conclude that “the frequency and intensity of positive and negative expressiveness in the family, as well as the quality of family relationships as a whole contribute to the emotional climate of a family” (p. 559). For this reason, it is important that we better understand how conflict within older families manifests itself, as where there is tension (Lashewicz & Keating, 2009) and stress (Lazarus &
Folkman, 1984) between siblings, there is a corresponding negative impact on familial interpersonal relationships (Willyard et al., 2008; Clarke et al., 1999; Braudy-Harris, 1998; Merrill, 1996; Stoller et al., 1992; Strawbridge & Wallhagan, 1991; Brody et al., 1989).

In situations of tension and stress, family members are faced with how best to cope with new demands. Coping itself is far from easy, as “both cognitive and behavioral efforts to “master, tolerate, or reduce external and internal demands and conflicts” must be well planned (Folkman & Lazarus, 1980, p. 223).

In her research on sibling relationships, Downing (1988) states

Although our culture seems to allow us the freedom to leave sibling relationships behind, to walk away from them, we tend to return in moments of celebration…as well as in times of crises… At such moments, we often discover to our surprise how quickly the patterns of childhood interaction and the intensity of childhood resentment and appreciation reappear. (pp. 10-11)

Additionally, Lashewicz & Keating (2009) argue that “as siblings negotiate their identities as participants in their parents’ later lives, their connections to each other are brought into focus” (pp.133-134). Adding nursing home placement of an older family member may escalate what may already be stressful family conditions (Gaugler, 2000; Gaugler et al., 1999). Older sibling relationships may generate increased sibling interpersonal conflict (Dayton-Ingersoll, et al., 2003; Bedford, 1989). For some siblings, “these conflicts can potentially be resolved, but it is never easy” (Pealer, 2008, p. 21). Research has shown, however, that sibling relationships can endure intense hostility because of the permanent nature of the relationship (Mikkelson, 2004).

Another significant factor that determines how individual family members decide who does what, how much, as well as what kind of caregiving, is sibling composition. The number of
siblings and the number of sisters and brothers impacts on the concept of filial responsibility (Davey & Szinovacz, 2008; Sarkisian & Gerstel, 2004; Campbell & Martin-Matthews, 2003; Martin-Matthews, 2002; Dautzenberg et al., 2000). Connidis et al. (1996) argue that:

In larger sibling groups, contributions are uneven, and commonly, two siblings provide most of the care, while the others help occasionally, when needed, or not at all. Major gender differences emerge when families have both brothers and sisters, with sisters far more often providing routine care and brothers more frequently providing occasional or no care. (p. 408)

Filial responsibility, to provide care to older family members, may also be harmed as a result of what Voorpostel et al. (2012) define as negative life events. When negative life events such as: divorce, physical illness, mental illness and addiction, problems with the law, abuse, and financial problems occur, caregiving may be sacrificed because the would be caregiver is unable to engage with her or his family.

As family members age, relationships, specifically relationships between parents and children, may deteriorate to the point where ambivalence is experienced by family members. In their discussion about ambivalence, Pillemer & Lüscher (2004) state that in situations of ambivalence,

Parents and children want to be independent of one another, knowing all the while that they are still mutually dependent. When both parties experience feelings of estrangement or even of hostility, they may…be burdened by a sense of indecisiveness, uncertainty, and drifting apart. (p. 25)

In families where there is more than one sibling to care for an older family member, ambivalence may irreparably harm the sibling relationship (Dayton et al., 2003).
The Cost of Nursing Home Care

Finally, another significant factor associated with nursing home placement is cost of caregiving services (Coghlan, 2009). Research shows that because of lower income African Americans and Latinos cannot access nursing home care (Wallace et al., 1998). The same situation holds true for older Mexican-origin Hispanics (Angel et al., 2003). In a study published in 2004 in the Journal of the American Medical Association, it was reported that for families taking care of a family member nearing the end of his/her life,

…yearly caregiving costs range from $3 billion to $6 billion for diabetes, more than $6 billion for stroke, and $65 billion for patients with Alzheimer disease. The economic disruption of family caregiving can be profound: 20% of family caregivers must quit work or make major life changes and 31% lose most or all of their family savings as a result of caregiving. (Rabow et al., 2004, p. 484)

Aoun et al. (2005) state that their

Research findings from the US indicate that many caregivers of terminally-ill patients with moderate or high care needs reported spending 10% of their household income on health care costs, that they or their families had to sell assets, take out a loan or mortgage or obtain an additional job to meet health care costs.

(p. 552)

In a 2009 report released by the National Alliance for Caregiving and the American Association for Retired Persons, it was reported

That 44 million American adults provide assistance to elderly and disabled adults in their community without any compensation. (Coghlan, 2009, p. 23)
In connection with informal care, research has shown this type of caregiving can potentially be more costly than formal caregiving options (Carpenter & Mak, 2007; Harrow et al., 2004). Byrne et al. (2000) argue that

Care provided by family members typically does not impose explicit financial costs, but the opportunity costs in terms of forgone earnings or nonmarket time can be substantial. (p. 1206)

In a minority of circumstances, some of the financial burden of providing informal care is offset by government financial assistance. For example,

At the provincial level, Nova Scotia is distinct within Canada for having a policy (enacted in 2009) entitling friend and family caregivers who provide more than 20 hours of care per week to a low income adult care recipient to receive a $400 monthly allowance. (Lashewicz, 2011, p. 15)

In the United States,

Medicaid is estimated to have served 31.4 million individuals in fiscal year (FY) 1992, at a combined cost of $118.8 billion, about 15% of total national health spending. (Congressional Research Service, 1993, p. 1)

Clearly, the older family members become, the more financial stress may become an issue. Financial stress is not simply defined as the cost incurred to provide either informal or formal care for older family members, but it also consists of number of days absent from work and ineffective job practices in the workplace (Phillips, 1995).
Informal and Formal Caregiving

When meeting the responsibility of adult caregiving, adult children utilize both informal and formal forms of social and medical support (Connidis, 2010; Choi et al., 2007). Informal unpaid caregiving is largely provided by family and friends and includes such activities such as emotional support, personal care, nursing care, assisted living (Kemp, 2012; Tolkacheva et al., 2011; Connidis, 2010; Charles & Sevak, 2005; Cantor, 1979). Informal family caregiving is therefore very complex (Li et al., 2012; Blum & Sherman, 2010) and it can be both physically and psychologically draining (Holland & Crowley, 2013; Harris, 2009; Bookwala et al., 2000).

In her discussion about informal caregiving, Scott (2000) states that
Informal caregiving is often considered to be a volunteer activity and/or choice freely made by family and relatives. As a result, friends, employers, community members, policymakers, and relatives themselves tend to see it as a personal issue between the caregiver and the person for whom he/she provides care. (p. 7)

In the United States, in 2006, there were “…52.4 million informal caregivers…” providing care for older family members (Scott, 2006, p.1). In Canada, “In 2007, the number of caregivers aged 45 years and older increased by over 670,000 to 2.7 million caregivers (Cranswick & Dosman, 2008, p. 50). Research shows that informal caregiving is very difficult (Bastawrous, 2013; Van Durme et al., 2012; Beckham & Giordano, 1995).

A second caregiving option is assisted caregiving. Assisted caregiving utilizes both informal and formal services where both family members and in-home paid caregivers deliver health services (Hoover & Roterman, 2012; Kemp, 2012; Connidis, 2010; Kemp et al., 2009; Griffin-Ward & Marshall, 2003). For example, Beacon Hill Village in Boston relies on both informal and formal caregiving (Blumenstock, 2007). In this model, older adults continue to live
independently, however, they can also take advantage of a number of services “such as concierge services, home health services, and social and cultural activities” (p. 42).

Formal paid support draws on the social and medical services of specific services of healthcare institutions and services (Connidis, 2010) with the most structured long-term form of formal support being nursing home care (Atchley & Barusch, 2004). Families, however, can also select from a variety of other formal care options such as formal in home care (Byrne et al., 2009), adult day care, and continuing care retirement communities (Hooyman & Kiyak, 2010; Lassey & Lassey, 2001). In their discussion on formal nursing home care, Infurna et al., (2013) argue that while:

Placement may … be perceived as a relief from everyday challenges associated with caregiving and thus result in a restoration of a caregiver’s sense of control over the events in his/her own life. A contrasting scenario is that placement will not alter change trajectories in mastery. New stressors may emerge …. (p. 203)

In addition to the distinction between informal and formal caregiving, caregiving itself can be either indirect or direct (Keefe & Fancey, 2000). Indirect caregiving, can occur if a parent lives in a nursing home or continues to live on their own, consists of advocating for older family members, communicating with medical staff, being accessible to the elderly parent should they require help with financial planning or with the purchase of clothing, maintaining a good relationship with nursing home staff and so on (Keefe & Fancey, 2000). Direct caregiving “… includes topics or components related to providing emotional and physical support, providing personal comforts, and being a link to the community” (Keefe & Fancey, 2000, p. 239). Typically, direct caregiving occurs when older family members require increased assistance.
Interpersonal Conflict

In their introductory discussion about conflict, Folger, Poole & Stutman (2001) state that human “conflict is the interaction of interdependent people who perceive incompatible goals and interference from each other in achieving those goals” (p. 5). This idea is echoed by Nye (1973) when he states that “conflict is defined as mutual hostility between or among individuals or groups” (pp. xi-xii). He argues that one way to begin to understand incompatibility and further explain conflict is by paying specific attention to the values and needs individuals hold (1973). Both values and needs determine how we interact with our surroundings and people, and our emotions and social skills (1973). Jeong (2000) argues that what is important to remember is that “… deep rooted conflict is embedded in interpretative dynamics of past history, psychological relationships, cultural norms, social values and belief systems of identity groups” (p. 36). Whether because of distinct individual values and needs, power imbalances (Wilmot & Hocker, 2001) or other structural factors (Schellenberg, 1996) conflict must be addressed so that both individuals and the larger social structure are able to function well.

Interpersonal conflict is an unavoidable and therefore inevitable aspect of human life (Lederach, 1995; Straus, 1979), and is found in every culture (Avruch, 1998). When defined, interpersonal conflict is said to be

A dynamic process that occurs between interdependent parties as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals. (Roloff & Chiles, 2011, p.424)

Conflict can be destructive (Smetana, 1996; Rutter et al., 1976) or constructive (Piaget, 1932; Dunn, 2004). Halevy & Katz (2013) argue “… that people’s motivational goals influence their mental representation of conflict…” (p. 222).
Similar to Halevy & Katz, Koerner & Fitzpatrick (2006) state that … conflict behaviors associated with positive outcomes are those that are direct and cooperative and focus on problem solving, whereas indirect and competitive strategies associated with asserting power and authority are associated with negative outcomes. (p. 177)

Interpersonal conflict may result contribute to resentment (Katz et al., 2011) a reduction in specific relationships or possibly even end the relationship so that interpersonal conflict no longer can occur (Barki & Harwick, 2004).

In their research about interpersonal behavior, Horowitz & Vitkus (1986) argue that interpersonal activity can be categorized on the basis of eight parts or octants. The eight octants are: “intrusive, domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, and overly nurturant” (p. 415). They state that these octants determine the extent of interpersonal problems (Horowitz & Vitkus, 1986). While in some circumstances interpersonal conflict may eventually bring about a positive outcome, while the conflict is occurring some individuals may experience harm and in extreme conflict situations even trauma (Meffert & Marmar, 2009).

In spite of potentially difficult interpersonal processes and outcomes, Oetzel & Ting-Toomey (2006) believe that Conflict, when managed competently, can bring about positive changes in a relationship. It allows the conflict partners to use the conflict opportunity to reassess the state of the relationship. It opens the doors for the individuals in conflict to discuss in depth their wants and needs in a relationship. (p. 65)

In the Western world, conflict is something that many individuals actively encourage (Dubler, 2005) and when resolved (Deutsch, 1973) promotes a situation of “mutual respect” (Katz et al., 2011, p. 94). In his discussion about conflict, Schellenberg (1996) explains that
“conflict resolution may occur through self-conscious efforts to come to an agreement, or it may come by means of (environmental change, the influence of third parties, victory for one party, and so on)” (p. 9). Like Nye, Katz et al. argue that “…all conflicts are about human needs. When you identify the human needs in the conflict you understand what lies beneath the parties’ presenting positions” (2011, p. 114). In his analysis of conflict, Bolton (1979) describes conflict resolution as a three-step process. 1) Treating others with respect, 2) Listening until one experiences the other’s side, 3) Stating one’s views, needs, and feelings (pp. 218-223). Conflicts that are resolved may then encourage increased understanding or what Coser refers to as “… associations or coalitions …” (Coser, 1956, p. 155) where individuals are able to effectively work together in a larger group. Similar to Coser’s definition of positive conflict, Putnam (2006) states that “functional conflict can prevent system stagnation, stimulate interest, promote cohesiveness in groups, help lead to change, and so forth” (p. xii). This positive aspect of conflict is underscored by Deutsch (1973) in his formative research about conflict and conflict analysis.

As part of the conflict resolution process, individuals may experience transformation. With this experience, “…transformation of the parties’ conflict itself from a negative and destructive interaction to a positive and constructive one – which represents both a private benefit to them and a public benefit to society …” (Bush & Folger, 2005, p. 21).

Finally, for some individuals, conflict resolution leads to forgiving their transgressors (Augsburger, 1992). Forgiveness itself, however, is far from easy. It may in fact involve some risk to individuals (Tutu, 1999). In some situations, forgiveness cannot take place as “the sense of hurt and betrayal is simply too deep …” (Canary et al., 2013, p. 195). For true forgiveness to occur, individuals must adopt long-term change in thought, action, and heart (Henderson, 2003;
Interpersonal Communication

Interpersonal communication is a critical component that helps define human relationships (Bambacus & Patrickson, 2008; Silberman & Hansburg, 2000). It is therefore extremely relevant when attempting to understand and address interpersonal family conflict. Maguire (2012) argues that it is relevant as communication strategies such as positivity (keeping the relationship upbeat and cheerful), assurances (committing to the continuance of the relationship), and openness (discussing the state of the relationship) are all examples of maintenance-focused coping responses, where partners engage in pro-social communication during stressful times in order to strengthen the relational bond. (p. 90)

Amongst aging families, “… age brings decline in certain aspects of functioning which in turn has consequences for communication …” (Harwood et al., 2013, p. 113). To recover some of the loss in functioning, individual family members turn to communication tools like hearing aids to assist them when they are communicating (p. 113). Family communication itself, is a product of “… all verbal and nonverbal behaviors by which family members affect one another and enact their interpersonal relationships with each other” (Koerner & Fitzpatrick, 2006, p. 160). Family communication thus has both a psychological or emotional component and an interpersonal component (Katz et al., 2011; Koerner & Fitzpatrick, 2006; de Vries et al., 2009). In families where there is more than one child, adult children many spend times reminiscing. In this type of situation, “Reminiscence in itself is simply thinking or talking about the past” (Cicirelli & Nussbaum, 1988, p. 293). Interpersonal sibling communication itself is something
that initially begins in early childhood. In their research on the development of interpersonal communication, Cicirelli & Nussbaum (1988) state that

In the early years, siblings may eat, sleep, bathe, dress, work, and play together. In these years, patterns of intimate communication develop between siblings as they talk about common family experiences. (p. 284)

They also argue that in adulthood, the experiential patterns linked with earlier childhood communication may actually be “…taken for granted” (p. 284).

As previously stated, interpersonal communication can be either negative or positive (Wilmot & Hocker, 2001). When interpersonal communication turns for the worse, confrontational remarks may be exchanged (Bolton, 1979). In this type of situation, “…confrontive remarks are used more and are reciprocated more readily when individuals blame one another for a conflict than when they blame themselves” Sillars & Wilmot, 1994, p. 174). Individuals adopt their own specific positions (Katz et al., 2011). In their research, Vangelisti & Crumley (1998) argue that these sorts of remarks are perceived to be much more harmful when made by a family member than a friend or colleague. Research also indicates that “…siblings’ perceived use of verbally aggressive messages is likely to decrease over the lifespan” (Myers & Goodboy, 2006, p. 3). Amongst some adult sibling relationships, however, envy and resentment (Gold, 1989) continue to impact on the sibling relationship. This then continues to damage sibling communication.

When interpersonal communication is positive, individuals are more willing to co-operate and this in turn reduces the risk of interpersonal conflict (Bambacas & Patrickson, 2008).
In their research on the significance of positive interpersonal communication, Katz et al. (2011) identify five steps that when successfully employed can facilitate interpersonal conflict resolution. The five steps are:

1. Listening to the other’s position using reflective listening skills.
2. Restating one’s position and identifying one’s interests.
3. Eliciting the other’s interests
4. Summarizing and gaining agreement on one another’s interests.
5. Resolving the problem that was the initial source of interpersonal conflict.

(p. 121)

Whether the interpersonal communication that we employ contributes to successful conflict resolution or it furthers interpersonal hostility, the way that we communicate serves to “…initiate, define, maintain, or further a relationship…” (Dainton & Zelley, 2005, p. 51). In my research study, poor interpersonal communication between adult siblings is delineated as one of the significant research findings that has contributed to family conflict.

Family Conflict

Regardless of what services and support are available and being used in families, the actual decision to place a family member in a nursing home is a very difficult one (Strang & Koop, 2006). In his now classic discussion about institutionalizing a parent, Stanley Cathy (1972) refers to the process of parent caregiving placement as a nadir of life – the lowest point; point of greatest adversity or despair a process adult children must face.

He argues that

Recognizing the need for a family decision about institutionalizing a parent can create conflicts so severe as to be catalytic or paralytic. Resolution of these conflicts
can lead to greater bonds between family members or to impenetrable, indissoluble barriers of hatred between them. (p. 26)

Family conflict and stress “…relates to how family members perceive themselves in relation to their older relative or loved one and what is expected to result from the relationship” (Dellasega & Mastrian, 1995, p. 124). Distinct from other types of nursing home-related conflicts, such as conflict between families and nursing home staff (Abrahamson et al., 2009; Kemp et al., 2009; Utley-Smith et al., 2009; Bauer, 2006; Nanni, 2004; Pillemer et al., 2003; Almberg et al., 2000; Iecovich, 2000) or conflict between families and a nursing home resident’s physician (Illhardt, 2007), conflict as it occurs within the family unit prior to, during, and after an older parent has moved to a nursing home is an area of research that deserves greater attention, as the demand for nursing home care in countries like the United States and Canada will only increase (Sehrawat, 2010).

Additionally, there are approximately 69 million baby boomers all of whom are aging (Sehrawat, 2010). It is reasonable to assume then, that many baby boomers will require nursing home care generating the potential for much nursing home-related placement conflict. While the current focus is largely on how nursing homes must be restructured so that they meet the demands of the baby boomer cohort (Hooyman & Kiyak, 2010; Blumenstock, 2006; Atchley & Barusch, 2004) greater focus also needs to be placed on the process of placement itself.

As part of the formal process of moving to a nursing home, families initially move through a pre-placement process (Cheek & Ballantyne, 2001). In the pre-placement process, families are said to move through four stages. They are “… recognition of the potential for institutionalization, discussion of the institutionalization option, implementation of action steps towards institutionalization, and placement of the relative in the institutional setting” Gonyea,
1987, p. 63). In his research on family conflict and institutionalization, Stanley Cathy argues that families may experience crisis in the pre-institutionalization stage, during institutionalization or in post-institutionalization (Cathy, 1972). He states that in connection with the three stages, “each has its unique configuration; each, of course, continues or resolves crises of the past and initiates conflicts and crises of its own” (p. 26). During the placement process, issues such as family structure, specifically whether the family functions as a collective unit or if it is individualistic in nature (Pyke, 1999), and other factors – some of which date back many decades – may encourage or discourage family consensus (Dayton et al., 2003; Roberto, 1999) often surface. Research shows that in families where there is more than one adult child,

A power differential that existed in childhood as a result of birth order or familial expectations regarding gender roles may persist into adulthood, causing conflict that affects eldercare decision making. (Gentry, 2001, p. 36)

Another important factor that determines degree of adult sibling involvement with older parent(s) care is level of caregiving participation. In their discussion on sibling participation, Pealer (2008) and Moyer (1992) state that there are five types of sibling caregiving participation. They are: the adult child who provides routine help, the adult child who provides backup help, the adult child who provides limited help, the adult child who provides sporadic help, and the adult child who provides no help. Clearly, in families where there are adult children, level of caregiving assistance to an older parent(s) will determine how much conflict is experienced either between the older parent(s) and the adult child or between several adult children/siblings.

In their research on family caregiving,

Placing an older family member in a nursing home is said to be “… traumatic for the resident and for the family” (Naleppa, 1997, p. 91). The emotional distress linked with trauma
may contribute to increased conflict (Maguire, 2012). The decision to move a family member to a nursing home is a difficult one (Buhr et al., 2006) where family members either accept and adapt to public care or actively avoid participating in it (Söderberg et al., 2012).

One of the chief reasons as to why some family members actively avoid participating in nursing home visits is geographical distance. The further away family members live from the nursing home, the less likely they are to be involved with regular caregiving (Dillman et al., 2012; Haberkern & Szydlik, 2010; Port et al., 2001; White & Reidmann, 1992; Bitzan & Kruzich, 1990; Lee et al., 1990; Greene & Monahan, 1982; Hook et al., 1982). In addition to this, long distance caregivers “… experience high levels of stress and dissatisfaction, perhaps because they receive less information than those able to see what is occurring first-hand” (Cagle & Munn, 2012, p. 703). In a research study on distance caregiver siblings by Roff et al. (2007)

A noteworthy finding was that some of these highly educated, distant siblings expressed a sense that the hometown siblings, who provided the bulk of the day-to-day care for parents, were inadequate or deficient in their caregiving. (p. 328)

They also state that

Distant caregivers are often overachievers who have very high expectations of themselves and who left their home communities to pursue challenging career paths. They may have trouble resolving their wishes simultaneously to be with frail parents and to meet job and family demands. (p. 330)

Each of these factors, either on their own or more than likely combined together, contribute to increased and complex family conflict. Unlike other types of interpersonal conflict, family conflict is said to distinct because “…family relationships often are perceived to be less voluntary and more obligating…” (Caughlin et al., 2011, p. 686). Additionally, family conflict
“at the behavioral level, is less avoided and more extreme” (p. 686). In his early research on family behavior, American sociologist, Jetse Sprey (1971), stated that

The family process is seen as one of exchange, that is, one in which the inputs of all members should, over time, balance each other, so that the kind of interpersonal harmony deemed necessary to family stability is maintained. (p. 725)

Interpersonal Conflict Theory, Developmental Theory, Life Span Theory, Equity Theory, Intersectionality Theory, and Multilevel Interpersonal Conflict Theory

One way that we can begin to understand how interpersonal conflict in families occurs prior to, during, and after nursing home placement, is by applying interpersonal conflict theory (Roloff & Soule, 2002). This theoretical approach argues “… that interpersonal conflict is related to lower levels of relational functioning but that the degree is moderated by a number of factors” (Roloff & Chiles, 2011, p. 429). In their theory on interpersonal conflict, Roloff & Soule (2002) argue that two of the most critical factors associated with this type of conflict are intimacy and individual perception. They state “… that conflict is more frequent and intense in intimate than in nonintimate relationships” (p. 491). The two reasons why frequent and intense conflict occurs in intimate relationships is because “… intimates engage in more joint activities and are more knowledgeable about each other …” (p. 490).

Interpersonal conflict is also heavily influenced by individual perception. When this occurs, “… individuals…perceive some sort of incompatibility and try to understand its source” (p. 499). Once perceived conflict has occurred, individuals will respond in one of four ways. The ways are: exiting the relationship, neglecting or being hostile to the relationship, forgiving the other individual, and fixing the problem so that the relationship when repaired can then continue (Roloff & Soule, 2011). In my research, in families where caring for an older parent
has contributed to interpersonal conflict, it is evident that each one of the four interpersonal options has been chosen by different research participants as an appropriate response in their family conflict situation.

Developmental Theory

A second way that family conflict in the context of caregiving for an older parent can be understood is through the application of developmental theory (Rodgers & White, 1993). This theory adopts a sociological approach where the specific stage of family development and length of time spent in each stage is significant (White & Klein, 2008) in explaining the process of family change. In family development theory “The family is a semi-closed system of interacting personalities which is composed of interrelated positions and roles defined by the society of which it is a part as unique to that system” (Rodgers, 1964, p. 264). Family development theorists argue that all families pass through stages that challenge and change family life (Aldous, 1990). They state that

… changes in family role organization and the pile-up of stressor events which precipitate critical transitions from one stage of development to the next involving processes of destruction, disorganization and reorganization. (Hill, 1986, p. 28)

Thus, there is

… a change in the age role content of any one of the several positions in the family requiring a rearrangement of role reciprocities. (Hill, 1986, p. 20)

In their discussion on development theory, Rodgers & White (1993) argue that there are three basic assumptions that explain how families change. Of the three, the assumption that is most applicable to conflict in families and nursing home placement of older family members is the third assumption. They argue that this assumption states “…that changes in family structure
are accompanied by transition events. In many societies, those events are recognized as “rites of passage” …” (p. 236). These rites of passage are themselves based on specific social norms (White & Klein, 2008) that are established in society. It is not implausible to argue that moving into a nursing home is a rite of passage for older families that is based on social norms that have long-since been established in the Western World. In addition to transition events and social norms, Rodgers & White (1993) state that family development is affected by two kinds of change – systematic and random. They state that “Systematic change has a pattern or regularity to it, whereas random change does not. Within systematic change it is possible to distinguish at least two other forms of family change: maturational change and adaptational change” (p. 242). Clearly, for older families systematic maturational and adaptational change explains the transition from home to nursing home as well as how family conflict may ensue. In the family development theory model presented by Watt & White (1999) a few years later, the retirement stage – the last of what they argue are seven distinct family development stages - serves as the basis for understanding older families (Jennings & Wartella, 2013, p. 450). Under the family development model, these life stages are inevitable (Laszloffy, 2002).

Life Span Theory

A third way that family conflict and nursing home placement can be understood is through life span or life course (Bengtson & Allen, 1993) theory. This theoretical approach is distinct from developmental theory as it combines psychological, ontogenetic, and sociological elements into one theory where focus is placed both on individual development and the multi-stage development of the family unit (White & Klein, 2008). In their research on life span theory, Heckhausen et al. (2010) state that
Individuals have to adjust to, cope with, and take advantage of the changing opportunities and constraints characteristic of different stages in life. Biological maturation and aging and societal institutions (e.g., education, labor market, retirement) set up a roughly inverted U-shaped curve of control capacity across the life span, with a steep increase during childhood and adolescence, a peak in young adulthood and middle age, and a decline in old age. (p. 34)

Life span theory is particularly relevant to understanding interpersonal conflict in older caregiving families as it argues that family relationships change as a result of the ages, phases, and familial connections of every family member (Cox & Paley, 1997; Elder, 1994, Cicirelli, 1988).

A major criticism of life span theory is that it is overly deterministic. In response, proponents of the life span approach argue that the theory successfully incorporates more in terms of “… the considerable impact that social norms and context have on individual development” (White & Klein, 2008, p. 141). The theory argues that “… human development and aging are a lifelong process” (Jennings & Wartella, 2013, p. 450. Family conflict and nursing home placement can thus be interpreted as something that is a product of biology (aging), psychology (acceptance and adjustment to the aging process), and social norms (reacting to and acting with prescribed social norms as they currently exist in connection with the process of aging).

Equity Theory

A fourth, and I believe the strongest, theoretical way that family conflict, aging, and nursing home placement can be understood in a comprehensive way is through the application of Equity theory (Adams, 1965). Similar to balance theory, where “If a person toward whom
we have positive feelings acts in a way of which we disapprove, we are in a state of imbalance” (Swenson, 1973, p. 252), equity theory argues that individuals will become distressed when they perceive a social situation to be unjust or unfair to themselves (Walster et al., 1978). Previous research (Dayton-Ingersoll et al., 2003; Lerner et al., 1989; George, 1986) has demonstrated that a key reason as to why siblings experience distress is because they perceive that an inequity in social relations between siblings exists within the family unit.

Close or personal relationships, like sibling relationships, are said to be characterized by their being interdependent, unique, and extremely emotional (Sillars, 1985). Equity theory - a social psychological theory – interprets situations where interpersonal relationships, when they have become unequal or inequitable, turn to dissent and discord. In one of the earliest discussions about equity and inequity, American behavioral psychologist, J. Stacey Adams (1965), stated

Inequity exists for Person whenever he perceives that the ratio of his outcomes to inputs and the ratio of Other’s outcomes to Other’s inputs are unequal. This may happen either (a) when both are in an exchange relationship or (b) when both are in an exchange relationship with a third party and Person compares himself to Other. (p. 280).

Madoff (1997) and Lashewicz et al. (2007) argue that one way that inequity sibling distress can occur is through sibling overbearingness or undue influence. In this type of situation, “Manipulation and coercion are obvious examples of undue influence” (Lashewicz et al., p. 98). I contend that through the application of equity theory we can begin to understand how it is that within some families – particularly, but not exclusively between siblings – prior to, during, and after nursing home placement of an older parent, conflict is experienced. Siblings
will engage in conflict when they believe that a life experience is unfair or unjust. Another situation where inequity may occur is in families where there is at least one adult daughter and one adult son. Research indicates “… that legitimate excuses used by siblings to forge psychological equity in parent care may be less available to sisters than to brothers” (Dayton-Ingersoll, 2003, p. 211). Sisters “… may feel less able than their brothers to use excuses such as employment or other family responsibilities to legitimize their underinvolvement” (Dayton-Ingersoll, 2003, p. 211). For families where there are, at least, two relatively healthy adult siblings whom are capable of caregiving for one older parent or perhaps two, inequity – conflict - occurs when one sibling is either forced to or willingly takes on the majority of the pre and post nursing home caregiving work. It is at this point that third party intervention – intervention such as mediation – becomes an important way of addressing and resolving interpersonal family conflict.

Intersectionality Theory

In her discussion on intersectionality theory, professor of American Studies and Women’s Studies, Jennifer Nash, states that “The term intersectionality, coined by legal scholar Kimberlé Crenshaw, underscores the ‘multidimensionality’ of marginalized subjects’ lived experiences” (2008, p.1). Originally employed to understand the lived experiences of black women (McCall, 2005), intersectionality theory can be applied to understand the complex lived experiences of caregiving women as they are themselves marginalized and therefore misunderstood by individuals who are not in that role. In their role of caregiving women, what is important is that “Personal narratives may aspire to situate subjects within the full network of relationships that define their social locations…” (McCall, 2005, p.1779). By sharing their personal narratives, families, nursing homes, and government may then be better able to address
the various complex nature of family conflict as it occurs in connection with nursing home placement.

Multilevel Model of Family Conflict

The final theoretical way that we can interpret family conflict prior to, during, and after nursing home placement, is the multilevel model (Canary & Canary, 2013) of family conflict. This model argues that for one to truly understand family conflict, it is important to first recognize that family conflict is comprised of four distinct but inter-connected levels. The levels are:

**Level I:** How has the individual family member experienced family conflict?

**Level II:** How have the relational process influenced conflict?

Relational processes include:

- Marital conflicts between individuals
- Interparental conflict and communication that impacts on children who are part of the family
- Parent-child conflict
- Inter sibling conflict

**Level III:** How has family-level conflict impacted on the family?

- Family Status: How has family structure contributed to family conflict? (Be it two parent, single parent, divorced parent, step parent, same gendered parent)
- Health: Are one of more family members physically and/or psychologically ill and if so how has this impacted on the family as a whole?
- Work-Life concerns: How have family members balanced their paid and unpaid work and living at home?
- Resiliency: How have family members responded to difficult life circumstances?
Level IV: How has the culture in which the family is based (European, African, Middle Eastern etc…) impacted on family conflict? (pp. 17-18)

When conducing my interviews, research participants discussed many of the areas that Canary & Canary (2013) identify and argue are important aspects of family conflict. Study participants spoke about their own individual perspectives on family conflict, their family of origin’s history of inter-sibling conflict, they addressed both physical and psychological factors that contributed to conflict, and how their family had traditionally responded to difficult life changing circumstances. The research data presented in Chapters Four - Seven addresses each of the four family conflict levels identified by Canary & Canary (2013) in their contemporary theoretical model about family conflict.

As I have discussed, interpersonal conflict theory as influenced by interpersonal communication place responsibility upon the individual. They each argue that individuals can change how they both interact and communicate with others thus either maximizing or minimizing conflict. Distinct from that approach, both developmental and life span theories argue that where individuals and families are in the life cycle will impact on how they will then address old age-related caregiving conflict. Equity theory incorporates both the individual perceiver as well as the unjust situation as the true basis for family conflict. Finally, the multilevel model argues that family conflict is something that occurs when individuals, individual relationships, and cultural demands impact on the family unit. Culture itself influences how we socially construct care both within an informal setting like the family as well as in formal caregiving settings like nursing homes.
Discussion of Region and Systemic Issues Associated with Nursing Home Placement

In a report on aging in Canada, released in 2011, it is stated that population aging in Canada is expected to accelerate between 2011 and 2031, as all people in the large cohort of baby boomers reach their senior years. Projections show that seniors could account for more than one-fifth of the population as soon as 2026 and could exceed one-quarter of the population by 2056. (Milan, 2011, p.2)

In New Brunswick, in 2012, the total population of the province was 756,000 (Statistics Canada – www.statcan.gc.ca/tables-tableaux/sum-som/101/cst01/demo02a-eng.htm). The total population of New Brunswickers living in a nursing home in 2012 was 4,318 individuals (www2.gnb.ca/content/dam/gnb/Departments/sdds/pdf/Statistical/Reports/NursingHomes/NursingHomes2012.pdf). In 1981, the median age of the population of New Brunswick was 28.1. In 2011, the median age was 43.7 (McLaughlin, 2012, p. 9). In a New Brunswick provincial government report on nursing home care published in 2012, the government stated that “A review of the financial assessment process for formal care, in particular co-pay models and the subsidization of long-term services, is an important step in the evolution of formal care in New Brunswick” (McLaughlin, 2012, p. 24). In the same report, the provincial government underscored that “… a priority is to provide supports to those older adults who may require services to manage chronic illness …” (McLaughlin, 2012, p. 25). Clearly, one way that support for individuals who require long-term support as a result of chronic illness will be delivered is through nursing home care.

Currently, in New Brunswick in 2013, the process of being admitted into a nursing home follows a multi-step approach. For families and family physicians who believe that a family member should move into a nursing home, the initial step is to contact the New Brunswick
Department of Social Development (New Brunswick 2012; Public and Legal Education Services New Brunswick (PLEIS-NB), 2011, p. 1). Only after the Department of Social Development (DSD) has assessed and approved an individual for nursing home placement does the application move forward (PLEIS-NB, 2011, p. 2). The choice of nursing home is restricted to “… 100 kilometers of the municipality …” where the individual lives (PLEIS-NB, 2011, p. 2). Individuals can choose which nursing home within that 100 kilometer radius they would like to move to (PLEIS-NB, 2011, p. 2). In terms of cost, “The maximum is $95 per day. On a monthly basis, this would amount to about $2,890” (PLEIS-NB, 2011, p. 5). For nursing home residents who cannot afford to pay the monthly cost, they can apply to the DSD for a financial assessment so that part of their nursing home payment is subsidized (PLEIS-NB, 2011, pp. 5-6). For nursing home residents who have been living alone, the DSD bases its subsidy decision on the individual resident’s monthly net income (PLEIS-NB, 2011, p. 7). For resident’s who have a spouse or a dependent, the DSD basis its subsidy decision on the family net income (PLEIS-NB, 2011, p. 8). Until the DSD’s subsidy decision is made, the individual nursing home resident is responsible for paying all nursing home costs (PLEIS-NB, 2011, p. 5). Any changes in the resident’s financial situation will change the DSD’s subsidy (PLEIS-NB, 2011, p. 9).

Chapter Two Summary

In this chapter I have discussed the dominant concepts found in the literature about family conflict and nursing home placement. I began by describing how nursing homes were initially established in the United States and Canada. I introduced three contemporary nursing home models – Eden Alternative, Pioneer Network, and Green House – that are attempting to move nursing home care away from the traditional medical model. I then discussed the significance of the concept of filial responsibility as a way to understand why some adult
children believe that it is their duty to assist their older parent(s). Caregiving itself is very much
gendered. More women than men are caregivers. Sibling composition – number of caregiving
adult children, the ages of adult children, and the genders of adult children – impacts on who will
care for an older parent. I have shown that both informal and formal caregiving are very costly.
Geographical proximity of an adult child or children to an older parent(s) has a significant
impact on which sibling(s) will act as a caregiver(s). An adult child or children who live closer
most often will do more caregiving than an adult child or children who live in a different
geographic region than the older parent(s). I have shown that there are five theoretical
approaches that when applied can help us better understand conflict in families and nursing home
placement. The six theoretical approaches are: interpersonal conflict theory, developmental
theory, lifespan theory, social psychological equity theory, intersectionality theory, and the
multilevel model of family conflict. Of these six theories, I argued that I favor social
psychological equity theory as it best explains how siblings experience conflict. I then presented
the admission policy, stipulated cost, and possible nursing home resident financial subsidy
associated with nursing home placement in the Province of New Brunswick. For some nursing
home residents and their families, nursing home care can be extremely financially exhausting.

In the following chapter, I will discuss the how qualitative research – specifically
transcendental phenomenology and semi-structured interviewing – can help us better understand
the lived experiences of individual family members who have faced conflict in their own families
as a result of caring for an older parent and eventual nursing home placement. To do this, I will
provide a detailed descriptive account of the steps that I followed in meeting the ethical
requirements associated with conducting research with human participants, how I recruited

research participants for this study, and how I then transcribed, coded, and analyzed my data. I also address how I, through the audit trail process, ensure the research rigor of my study.
Chapter 3 – Methodology

Qualitative Research Design

In their analysis of the use of qualitative methods in research, Giacomini & Cook (2000) argue that

The Methods section of a qualitative study should describe several aspects of the research design, including (1) how study participants were selected, (2) the methods used to generate data, (3) the comprehensiveness of data collection, and (4) procedures for analyzing the data and corroborating the findings. (p. 358)

In this chapter I will present and discuss each of these four qualitative research methodology objectives. Before I do this, however, I will briefly discuss the advantages of qualitative research when conducting research with human research participants.

When analyzing data, researchers can follow a qualitative, quantitative or mixed-methods approach (Creswell, 2013; Nachmias-Frankfort & Nachmias, 2008; Biber-Hesse & Leavy, 2006) as a way of facilitating their study. It is argued that “True appreciation of each of the two paradigms is to accept the strengths, the expertise, and the contribution of each” (Morse, 1996, p. 5). In the research area of conflict and interpersonal relations, quantitative instruments such as the Conflict Tactics Scale (Straus, 1996; 1990; 1979), Interpersonal Conflict Questionnaire (Laursen, 1993), the Network of Relationship Inventory (Furman & Buhrmester, 1985), and the Two-Dimensional Model of Conflict (Blake & Mouton, 1971) have successfully statistically measured the level of conflict in human relationships. In my study, I analyze data through a qualitative lens as I believe that this method best allows me to understand the complexities and nuances (Chenail, 1995) of conflict as it occurs within older families prior to, during, and after nursing home placement. The family conflict that I am interested in knowing more about is a
very personal one for research participants. I am therefore in a very privileged position as they have voluntarily consented to share their own private lived experiences with me. For this reason, I believe that my research closely follows the “process” for qualitative research described by Denzin and Lincoln (2003). In their discussion about the role of qualitative researchers, they argue that

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is being studied, and the situational constraints that shape inquiry. They seek answers to questions that stress how social experience is created and given meaning. In contrast, quantitative studies emphasize the measurement and analysis of causal relationships between variables, not processes. (p. 13)

Documenting its early use as a research tool in the humanities and social sciences, “Qualitative research finds its formal and intertwined roots in the traditions of cultural anthropology and American sociology” (Kirk & Miller, 1986, p. 32). It therefore has a very long and rich research history.

In her discussion of the advantages of qualitative research, American sociologist, Kristin Esterberg, states that “Instead of trying to extract abstract categories from social phenomena as quantitative scholars do, qualitative researchers try to understand social processes in context” (2002, p. 2). Marshall & Rossman (2011) argue that “Because thoughts, feelings, beliefs, values, and assumptions are involved, the researcher needs to understand the deeper perspectives that can be captured through face-to-face interaction and observation in the natural setting” (p. 90). They also underscore that it is important for qualitative researchers to be mindful of the fact that they are entering the lives of research participants for a “…relatively brief but personal…”
period and as such researchers must be transparent and open with their research participants so that they feel safe and comfortable sharing their experiences (pp. 112-114). In my research, I seek to capture the social processes, thoughts, feelings, beliefs, and values of individual research participants within families that experienced conflict prior to, during, and after nursing home placement.

There are several distinct ways of conducting qualitative research (Creswell, 2013; van den Hooaard, 2012). Qualitative research may be based on case study (Stake, 1995), ethnography (Hammersley & Atkinson, 2007), grounded theory (Charmaz, 2006), narrative (Clandinin, 2007), or phenomenology (Moustakas, 1994). Whatever way is selected, “qualitative research is time-consuming, labour-intensive, and both imaginatively and emotionally demanding” (Smith et al., 2009, p. 42). The qualitative methodology that I analyzed my interview-based research was modified transcendental phenomenology (Cooper, 2010; Lindseth & Norberg, 2004; Pollio et al., 1997).

In his discussion about phenomenological research, Creswell (2013) states that “The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence …” (p. 76). Like Creswell, the focus placed on multiple common lived individual experiences is underscored by Moore & Bailey (2013) when they state that when conducting phenomenological research “… The purpose is to identify the core meanings of shared experiences of individuals within a particular phenomenon” (p. 7). Phenomenology (Marshall & Rossman, 2011; Merriam, 2009; Smith et al., 2009; Lundquist, 2008; Moran, 2000; Murray & Chamberlain, 1999; Embree, 1997; van Manen, 1997; Carpenter, 1995; Moustakas, 1994; Becker, 1992) then, is particularly well suited to better understand the
lived experiences linked to human aging, caregiving, nursing home placement, and family conflict.

In her discussion about the usefulness of phenomenological research, Dukes (1984) states that

Phenomenology starts with a double insight. First, human experience is intelligible – it makes sense – to those who live it, prior to all interpretation and theorizing. Second, the sense or logic of human experience is an inherent structural property of the experience itself, not something constructed by an outside observer. Human experience is meaningful to those who live it, and its meaning is there to be “seen,” grasped directly. (p. 198)

Phenomenology was initially introduced as philosophical theory by Edmund Husserl (1859-1938) (Smith, 2007; Sokolowski, 2000; Spiegelberg, 1965) an early 20th century Austrian-born mathematician and philosopher and then modified and used by his student, German philosopher Martin Heidegger (1889-1976) (Moran, 2000). Husserl believed that “… a critical analysis and description of the world of concrete “lived experience” must always take priority over the world as it actually exists” (Porter & Robinson, 2011, p. 52). His was a phenomenology of hermeneutics. In their discussion on the different approaches to phenomenological research, Zenobia et al. (2013) state that there are seven ways of conducting phenomenological research. In his discussion on phenomenology, Sailor (2013) narrows this down to two principal approaches which he states follow either a hermeneutical or interpretive approach.

Hermeneutical or transcendental phenomenology was popularized by American behavioral psychologist Clark Moustakas (1923-2012) (1994). Moustakas argued that transcendental phenomenology, in particular, is an appropriate way of understanding individual
lived experiences because it can “… provide an understanding of how it is that particular
perceptions, feelings, thoughts, and sensual awarenesses are evoked in consciousness with
reference to a specific experience such as jealously, anger, or joy” (p. 22).

Transcendental/Hermeneutical phenomenology is distinct from interpretive phenomenology
where “… phenomenology uses interpretation (based on Heidegger’s philosophy) to understand
the meanings of phenomenon” (Olausson et al., 2013, p. 235). Following the transcendental
approach, Epoche/Bracketing, Reduction/Horizontalization/Clustering, Imaginative Variation,
Integration/Synthesis, and Textural-Structural Description serve as the basis of this type of
qualitative research (Sailor, 2013).

Epoche/Bracketing

The first step in the transcendental phenomenological method/process is the epoche or
bracketing step. Following this step, researchers are encouraged to - without bias or
preconceived thoughts - consider what it might mean for research participants to have
experienced a specific lived event (Moustakas, 1994). Moustakas argues that when
“bracketing”, “… the world is placed out of action, while remaining bracketed. However, the
world in the bracket has been cleared of ordinary thought and is present before us as a
phenomenon to be gazed upon, to be known naively and freshly through a “purified”
consciousness” (p. 85). Moustakas’ idea of bracketing, rests heavily on Husserl’s initial model
of transcendental phenomenology. In this model, “Husserl (1929/1973) thought that accurate
essential intuition required a kind of prior mental purge of the untutored natural attitude that
clutters the actual phenomena of lived experience with inessential factual assumptions”
(LeVasseur, 2003, p. 413). He argued that for individual researchers to successfully bracket,
they must free themselves “… from prejudices and previous understandings and secure a level of detachment…” (Finlay, 2011, p. 46).

Phenomenological Reduction/Horizontalization/Clustering

The second step, phenomenological reduction or “horizontalization”, is based on bracketing. Knowledge from data is “clustered” or grouped into specific significant themes. Horizontalization can be described as a type of brainstorming, where different possibilities are raised and then reflected on based on the interview data that has been collected.

Imaginative Variation

The third step, imaginative variation, based on horizontalization, Moustakas (1994) states that in the imaginative variation step, “Free imaginative fancy is coupled with reflective explication giving body, detail, and descriptive fullness to the search for essences” (p. 99). Essences serve as the basis of the overall experience of interviewees (family members) and conflict as a result of nursing home placement.

Integration/Synthesis

In the fourth step, what is important to remember as a result of having moved through the four-step transcendental phenomenological process is that “One learns to see naively and freshly again, to value conscious experience, to respect the evidence of one’s senses, and to move toward an intersubjective knowing of things, people, and everyday experiences” (Moustakas, p. 101).

Individual Textural-Structural Description

The final step in the transcendental phenomenological method of qualitative inquiry invites the researcher to reflect on and include textural and structural descriptions from each interview as shared by all research participants. Both of these descriptive accounts “…come
together to create a greater description, comprehension, and understanding of the experience…” (Sailor, 2013, p. 7).

**Interpretive Phenomenology**

Distinct from the transcendental approach, is interpretive phenomenology (Smith et al., 2009). In her discussion on the purpose of interpretive phenomenology, Benner (1994) states that “…because persons are fundamentally self-interpreting beings for whom things have significance, understanding human action always involves an interpretation, by the researcher, of the interpretations being made by those persons being studied” (p.55). Benner’s argument in support of researcher research data interpretation is echoed by van Manen (1997) when he says that”…the “facts” of lived experience need to be captured in language … and this is inevitably an interpretive process” (p. 181). Interpretive phenomenology follows six research endeavors (Creswell, 2013). In his discussion on interpretive phenomenology, van Manen (1997) states that researchers are invited to: 1) Learn about the nature of the lived experience, 2) Investigate the experience as it has been lived, 3) Reflect on the themes linked to the lived experience, 4) Write and rewrite the themes until the lived experience is captured, 5) Possess a strong interest in listening to research participants, and 6) Understanding that research is both made up of parts, but is also a whole (pp. 30-34).

**Modified Transcendental Phenomenology**

In my research design, I followed a modified van Kaam (1966, 1959) transcendental phenomenological approach. Like Cooper (2010) and Lindseth & Norberg (2004), I did not believe that I could successfully “bracket” myself from my social environment as both Husserl and Moustakas demand transcendental phenomenological researchers do. Because I had experienced interpersonal family conflict prior to, during, and after when my mother-in-law
moved into a nursing home, I knew that it would be virtually impossible for me to bracket those interpersonal conflict experiences. After all, my lived experience with my mother-in-law’s aging process, her increased need for care, and the family conflict that ensued was the initial reason why I became interested in this research area. Instead of following a naïve or pure phenomenology (Breitholtz et al., 2013), I followed a modified transcendental phenomenological approach described by Pollio et al. that encourages the researcher to use a personal statement (1997). Thus, I completely rejected the idea of epoche/bracketing (Cooper, 2010; Lindseth & Norberg, 2004) and acknowledged my own lived experience.

In addition to developing and then sharing my personal statement, like Cooper (2010), I followed an existential phenomenological model when analyzing my data. Pollio et al. (1997) state that under this model, “the existential concept that applies here is that being is never isolated from the world but is always experienced as in-the-world” (p. 15). Instead of attempting to isolate my own family experience with conflict and nursing home placement, I acknowledged this experience with my research participants – through sharing my personal statement – at the beginning of each of the fifteen interviews that I conducted.

As stated, the focus of my research was to understand the family conflicts that occurred prior to, during, and after nursing home placement. To facilitate the research process, I developed three research questions. They are:

1) How does conflict occur within families who have placed a family member in a nursing home?

2) Utilizing transcendental phenomenology, how can we better understand conflict in families who have placed a family member in a nursing home?
3) What kind of conflict resolution practices and social policies can be put into place to assist families should they experience conflict as a result of nursing home placement?

Ethical Issues

In their discussion on researchers and ethical conduct, van den Hoonard & van den Hoonard (2013) state that

The researcher endeavors to be honest in his relationships with colleagues; admits to errors, missteps, and mistakes; and confesses the pressures of scholarship he is experiencing. He is trustworthy; takes time to do research, analysis, and writing; and values integrity when doing the analysis. (p. 16)

When conducting research with humans, it is critical that ethical research practices are followed so as not to risk harming research participants. Research participants only agree to take part in research on the basis of informed consent. To prevent any possible risk from occurring to my research participants, throughout my research study I adhered to strict ethics protocol (van den Hoonaard, 2002). I did this by following very specific steps. Prior to submitting my Research Ethics Board (REB) and Institutional Review Board (IRB) applications and interviewing research participants, I completed the mandatory CITI Ethics Training Program offered through Nova Southeastern University and initially obtained (CITI Reference ID # 4949846) later, during the final drafts of my dissertation writing process, renewed to (CITI Reference ID # 11761282). Because I conducted my research in central and northwestern New Brunswick, Canada, after I had completed CITI Ethics Training, I initially submitted an ethics application along with my interview guide (see Appendix B), research explanatory letter, and Nova Southeastern University’s consent form to the Ethics Review Board (REB) at St. Thomas University – the small liberal arts undergraduate university where I teach - for their ethics

As I have stated, informed consent is a critical component of conducting research with humans. Unethical research with humans, such as the Tuskegee syphilis experiment with African American men in the 1930s in Macon County, Alabama (Grey, 1998) and the horrific experiments that were committed by the Nazi doctors against Jewish internees at the Auschwitz and Dachau concentration camps during the Second World War (Lifton, 2000) has had a powerful and profound impact on why all human research subjects must be completely informed of their role in the research that they are voluntarily participating in. For this reason, in the consent form, I outlined the purpose of my study, how I would protect research participant anonymity, and how I would store the interview audio recording, signed consent form, and interview transcript. Research participants were also made aware that they had always had the option of either stopping the interview or withdrawing from my research study altogether.

After my proposed research was given “on-site” ethics approval by the REB at St. Thomas University, I then submitted their approved ethics forms together with the completed ethics forms to Nova Southeastern University’s Institutional Review Board (IRB). Only after I had received ethics approval from both the REB at STU and the IRB at NSU did I begin searching for research participants to interview. When advertising, I developed a one-page poster (see Appendix A) where I briefly introduced myself, outlined my research area, and described who I wanted to interview. On the poster I also included both the STU ERB and the
NSU IRB ethics protocol numbers that had been assigned to my research study and my
confidential email address and telephone number.

When I concluded interviewing research participants, following REB protocol, I reported
back to the REB at STU and informed the ethics committee that I was no longer interviewing
research participants for my study. The REB then informed me that because I was no longer
interviewing human subjects, my research file would be closed. In addition to reporting back to
the REB, I also submitted a Continuing Review Report to the IRB at NSU as required of
researchers who are still analyzing their research data. My research study was subsequently
approved by the IRB allowing me to continue with the process of analyzing the data that I had
gathered.

As part of my ethics protocol, prior to my interviewing research participants, I informed
every interview participant of the nature and purpose of the research (Esterberg, 2002). In her
discussion about ethics and qualitative research, Esterberg states that generally, qualitative
researchers should ask themselves five questions.

How should we conduct research so as to not hurt others?
What kinds of relationships should we attempt to create with our research subjects?
What kinds of power relations are there between those who are doing the research
and those who are being researched?
Who benefits from social research?
Who should benefit? (p.44)

Prior to every interview, I read through and reflected on Esterberg’s ethics questions.

In addition to informing every research participant about my research study, a critical
aspect associated with conducting research with human subjects is respecting the confidentiality
of research participants (Biber-Hesse & Leavy, 2004). Confidentiality is especially important when interviewing because “As a result of the interviews, sensitive information could be revealed to the interviewer” (Cater et al., 2013, p. 7). To preserve the confidentiality of my research participants, I invited each participant to choose their own pseudonym as a way of including them in my research. For individuals who did not choose a pseudonym, I randomly assigned them a name. I also changed the names of any specific communities that were mentioned by some of my research participants during the course of the interview. All audio recordings of interviews along with interview transcripts and signed consent forms were stored in a locked filing cabinet at St. Thomas University located in Fredericton, New Brunswick, Canada. I also password protected my laptop computer to add another additional layer of security that protect the identity of my research participants.

Research Sample

To facilitate my qualitative research study, I based my research on a sample of fifteen female research participants from central and northwestern (see Appendix E) New Brunswick, Canada. When advertising for research participants, I emphasized that I was looking specifically to interview individuals whose family had experienced interpersonal conflict in connection with caregiving and nursing home placement.

Participants were found through four means: 1. I placed research recruitment posters in five larger local grocery stores, two local senior centers, the local branch of the Alzheimer’s Society of New Brunswick, the local branch of the Red Cross of New Brunswick, and the local public and university libraries located in Fredericton, New Brunswick, Canada. As stipulated by my dissertation committee members during the initial dissertation research proposal meeting, I did not contact or place research recruitment posters in nursing homes. 2. I contacted the Third
Age Center (a research center at St. Thomas University whose mandate is to research and educate individuals on issues that are of specific concern to seniors) and asked if they would advertise my call for research participants in their electronically circulated newsletter (see Appendix C). 3. I submitted a letter to the editor to the only widely read newspaper that is distributed in Fredericton - the small city that I live in. 4. I spoke with individuals who I thought might be able to assist me with snowball sampling (Esterberg, 2002). The major advantage associated with the snowball sampling technique is that “…for hidden populations or groups of people … this may be the only way to recruit interviewees” (Esterberg, 2002, p.93). Utilizing this sampling technique proved to be a successful way for me to contact research participants.

While snowball sampling is a very useful way of finding research participants, it is not without its flaws. Perhaps the most significant flaw is that snowball sampling can contribute to sample bias ( Heckathorn, 1997). Four factors contribute to sample bias:

1) Individuals who initially volunteer to participate in research do so with a specific bias and therefore all subsequent participants are biased. 2) Bias exists simply because participants cooperate with the research. 3) Snowball referrals protect potential participants who other participants believe must be protected. 4) Referrals are made within a specific network of individuals. (pp. 174-199)

I am confident that I successfully overcame the possible problem of sample bias by using three additional methods of recruiting research participants.
Data Collection

Interviews

As I have already indicated, a critical component linked my qualitative research was the interviewing process. Warren (2013) argues that

Interviews represent one of the most effective ways to collect qualitative research data because they provide the researcher with opportunities for rich data and meaning making. (p. 1)

In addition to Warren’s emphasis on gathering rich and meaningful interview data, Beiten (2008) states that interviewing is particularly advantageous when researching families. Although phenomenologists prefer the term co-researcher (Moustakas, 1994) over research participant (Pollio et al., 1997), when analyzing and discussing the statements and ideas shared in interviews, I use the term research participant as this is the term that most qualitative researchers currently use.

The semi-structured retrospective interviews (Rivera-Segarra et al., 2014; Rubin & Rubin, 2012; Waldrop et al., 2012) were each approximately one hour to one hour and a half long. The interviews generated rich and meaningful data (Miles, 1979) because to a great extent they were based on spontaneous conversations (Finlay, 2011) that took place (with the exception of one which took place in an office at St. Thomas University) in the homes of research participants often in their kitchen over tea and food.

As for scheduling interviews, I initially began interviewing in early December 2012. I completed my last interview in late April 2013. I interviewed fifteen research participants although the IRB at NSU had approved a maximum of twenty-five possible research interview participants. All interviews were audio recorded and then transcribed by me following each
interview. All research participants who consented to be interviewed were female, Caucasian, and English speaking. The age of interview participants ranged from 45 to 64. With the exception of two families, one which constituted one adult child and the other two adult siblings, the majority of interview participants who spoke with me were from large families where there were five to seven adult male and/or female siblings. In every interview, discussion about caregiving and family conflict centered around whom, how much, and when did caregiving occur. With the exception of one research participant who spoke about caring for an older father, every research participant spoke about caring for an older mother. The research participant’s primary caregiving concern was to protect their older parent’s well-being.

Prior to beginning each of my interviews, I shared my personal statement with my research participants. In this statement, I briefly outlined my experience with family conflict, caregiving, and nursing home placement. I also invited research participants to read through and then sign the consent form that had been approved by the IRB at Nova Southeastern University. I provided research participants with a copy of the consent form one week prior to their interview with me. I also gave each participant their own copy of the consent form as stipulated by the NSU IRB ethics committee.

In her discussion about interviewing, Esterberg (2002) states that she views “…interviewing as a form of relationship between two individuals…” rather than simply as a situation where “the interviewer asks questions, and the interviewee responds to them” (p. 84). I attempted to approach my interviews with the idea of relationship in mind – albeit a temporary relationship - and not simply my being the one who was asking research participants’ questions. Esterberg’s idea that interviewing should be approached as relationship between interviewer and interviewee strongly compliments phenomenological interviewing. Pollio et al. (1997) state that
“Within the context of phenomenological interviewing, questions have a descriptive and facilitative purpose rather than one of assessing a preexisting opinion, attitude of level of knowledge” (p. 35). They also argue that “The questions, statements, and summaries used by the interviewer are designed to evoke descriptions, not to confirm theoretical hypothesis” (p. 30).

To encourage the type of descriptive and facilitative purpose underscored by both Esterberg and Pollio et al., all of my interviews, as I have already indicated, were semi-structured (Abrahamson et al., 2013; Rubin & Rubin, 2012) interviews. The chief advantage of semi-structured interviewing is that

… interviewees have more control over the course of the interview than in structured interviews, particularly in terms of deciding what and how much they want to reveal. However, interviewers also have control over the interview process, for example through active listening and asking questions. (Vähäsantanen & Saarinen, 2012, p. 494)

Rubin and Rubin (2012) state that “In the semi-structured interview, the researcher has a specific topic to learn about, prepares a limited number of questions in advance, and plans to ask follow-up questions” (p. 31). The three principal prepared questions (see Appendix B) that I asked when beginning my interviews were: 1) Tell me about yourself? 2) Tell me about your family? 3) I am interested to learn more about how family members experience the process of placing a family member in a nursing home, and the conflict that can result from this process. I just want you to tell me about your experience. You can start where you want, and end where you want, I just want to hear your story. (Question three is a modified version of a question initially introduced into qualitative research by van den Hoonard (2001) when she conducted her research on the life experiences of widows.)
The interviews thus required that I actively listen (Berg, 2009) to research participants tell me about their experiences with the process of placing a family member in a nursing home and the conflicts among family that arose during this process. While a limited number of questions are prepared in advance of the actual interview, in semi-structured interviewing, the researcher needs to listen carefully to the participant’s responses and to follow her or his lead. Esterberg (2002) argues that this process resembles a dance, in which one partner (the interviewer) must be carefully attuned to the other’s movements. Semi-structured in-depth interviews allow the researcher to ask prepared questions, but also provide flexibility to ask questions that emerge from the participant’s responses. Some of the unplanned questions that I asked were: Can you tell me some more about your childhood relationships with your siblings? Why do you think that your sister has taken so much control when caregiving for your father? You have said that two of your siblings approached caregiving for your mother from a clinical perspective, tell me more about how this has happened? You have told me about the conflicts that your family experienced while your mother/father was being placed in a nursing home and some of the conflicts that your family has experienced during the time that she/he has been living in the nursing home, can you tell me what you think the future might look like? If you were to offer a family advice as to what to do or not to do when placing a family member in a nursing home what would you say? What might you have done differently now that you know what you experienced in terms of family conflict and nursing home placement?

Rubin and Rubin (2012) argue that a critical part of the in-depth interview is asking probing questions. They state that:
Main questions cover all parts of the research problem, while probes keep the conversation on target and encourage the interviewee to provide depth and detail.

(2012 p. 132)

By encouraging the conversation to continue through the use of follow-up questions, more is learned about the subject that is being researched. For example, I learned that family history plays a very important part in this type of conflict situation. I also learned that some of my research participants were apologetic for their siblings’ ambivalence for initially not helping to care for and then for not visiting their older parent at the nursing home. Many felt genuine regret that their sibling had not been actively involved and believed that their sibling(s) had somehow missed-out in sharing the last years of their older parent’s life. With the exception of five research participants, who told me that they had done so, the individuals who I interviewed had not talked about their family caregiving conflict with anyone else outside of their immediate family. They stated that they were willing to talk with me for two reasons. First, I had ensured their anonymity. Two, what I was doing was research and they stated that they wanted to help other families who might also have experienced family conflict in connection with caregiving for an older family member and eventual placement in a nursing home.

Transcribing

A critical aspect of interviewing is transcribing. “Transcribing the interviews yourself forces you to pay attention to what interviewees said and helps you prepare for the next interview” (Rubin and Rubin, 2005, p. 204). Transcribing is also beneficial as it promotes reflexivity (Creswell & Miller, 2000) on the part of the researcher. Reflexivity itself
implies a shift in our understanding of data and its collection – something that is accomplished through detachment, internal dialogue, and constant (and intensive) scrutiny of “what I know” and “how I know it”. (Hertz, 1997, vii-viii)

Reflexivity also brings research study readers

… more closely into the story or narrative to increase coherence and to evoke feelings for and a sense of connection with the participants in the study. (Carlson, 2010, p. 1104)

Interviews were transcribed by me shortly after the completion of the interview. While some qualitative researchers argue that at this stage in the qualitative research “process” it is mandatory, as a way of ensuring the credibility of qualitative research, to invite research participants to review the interview by member checking (Marshall & Rossman, 2011; Buchbinder, 2010; Taylor & Bogdon, 1998) the interview transcript, I believe this to be a potentially problematic practice. Member checking is problematic as it may facilitate more damage to interview-based research than good. Through the process of member checking, some research participants may ask that some of their statements be altered thus harming the actual credibility of the research as well as the credibility of the researcher (Goldblatt, 2011; Carlson, 2010; Buchbinder, 2010). In their research in this area, Lincoln & Guba (1985) term this research data problem as “conspirational agreement” (Lincoln & Guba, 1985 as cited in Doyle, 2007, p. 894). They argue that for qualitative researchers to secure data trustworthiness it is critical that they establish an audit trail that details the various practices that were utilized when conducting their research study (Guba & Lincoln, 1981).
Audit Trail

In their discussion on research convincement grounded in lived experience, Ward et al. (2013) state that

There is no single recommended best practice for qualitative data analysis, but it does need to be transparent and auditable to improve the quality of its findings. (p. 2429)

Somewhat earlier, Mays & Pope (1995) argued that

… the basic strategy to ensure rigor in qualitative research is systematic and self-conscious research design, data collection, interpretation, and communication.

Beyond this, there are two goals that qualitative researchers should seek to achieve: to create an account of method and data which can stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions; and to produce a plausible and coherent explanation of the phenomenon under scrutiny. (p. 110)

Audit Trails have been used in quantitative research (Shepherd et al., 2012; Shepherd & Yu, 2011). In qualitative research, the audit trail has a lengthy history (Guba, & Lincoln, 1981; Halpern, 1983). As stated, it is used to ensure the reliability and validity of data (Akkerman et al., 2006; Whittemore et al., 2001; Long & Johnson, 2000; Maxwell, 1992). To ensure that the data that I gathered and based my research findings on was reliable and valid – trustworthy data - I followed the following audit steps.

1. I employed purposeful sampling (Metzger et al., 2013) by only interviewing research participants who had experienced conflict in their family as a result of caring for an older family member and then their experience with family conflict during and after nursing home placement.
2. I also actively sought-out peer debriefing (Goldblatt et al., 2011) from experienced on-site qualitative researchers who conduct qualitative research at the same university where I currently teach at.

3. I kept extensive notes that I recorded after each of my interviews where I described the ease with which the interview conversation had proceeded, the length of time that the interview had lasted as well as whether or not the interview research participant either struggled with the interview conversation or stressed a specific conflict(s) that their family had experienced.

4. I also maintained and listened to each interview audio recording (Carlson, 2010) and reread each interview transcript multiple times for accuracy as a way for me to continue to engage with my research data.

5. I maintained the process of engaging with the data throughout the period of collection analysis of the data and the writing of the actual dissertation to ensure I maintained the elements of phenomenological rigor.

6. Finally, I asked both my on-site qualitative supervisor as well as my primary committee supervisor to read through several drafts of my dissertation for trustworthiness.

In his discussion of the critical significance of the audit trail, American social welfare theorist, Glenn Bowen (2009), states that

The trail provides a means of ensuring that concepts, themes, and ultimately the theory can be seen to have emerged directly from the data, thereby confirming the research findings and grounding them in evidence. (p. 307)
Distinct from the positive assessments on the usefulness of audit trails in qualitative research made by Bowen (2009), Akkerman et al., (2008), Whittemore et al., (2001), and Long & Johnson (2000), two arguments challenge the usefulness of audits in qualitative research. Some argue that “The debate surrounding the use of the terms validity and its qualitative alternative, credibility, in qualitative research has been the subject of numerous discussions (Creswell, 2007; Long & Johnson, 2000; Morse et al., 2002; Whittenmore et al., 2001), but is without resolution” (Coker et al., 2013, p. 2). Others argue that rigor in qualitative research is to a great extent based on the credibility of the researcher(s). Patton (1999) states “… that the researcher’s own credibility affects the way findings are judged. Information about the researcher such as personal connections to the setting and study, training as an observer or the particular phenomenon under study, and the perspective brought to the setting ought to be reported” (Coker et al., 2013, p. 2). Keeping both of these arguments in mind, I am confident that I have captured the concepts, themes, and theory rooted in the qualitative research data and data analysis that defines my study.

Coding

In the phenomenological research that has looked at aspects associated with human caregiving (Nanni, 2004; Paul 1999), phenomenology has proven to be fruitful. When conducting phenomenological data analysis, it is understood that “the meaning one creates in the world is socially constructed…” (Boswell and Cannon, 2007, p. 171). In interview-based qualitative research, a critical practice that promotes understanding is coding the interview (Bernard & Ryan, 2010).

In his discussion on coding qualitative research, Saldaña (2009) breaks down the coding process into first and second cycle coding. This is the coding terminology and model that I too
use. Other qualitative researchers use the terms initial and focus coding (Lofland et al., 2006), open coding (Strauss & Corbin, 1998) or naïve and structural coding (Breitholtz et al., 2013; Lindseth & Norberg, 2004). Saldaña states that in the first cycle, it is useful to initially code data “…into seven subcategories: Grammatical, Elemental, Affective, Literary and Language, Exploratory, Procedural, and a final profile entitled Theming the Data” (p. 45). In second cycle coding, he argues that “The primary goal…is to develop a sense of categorical, thematic, conceptual, and/or theoretical organization…” based on first cycle coding (p. 149).

When analyzing my interview data, I initially began by listening to each audio recording of my interviews when transcribing. As previously indicated, I listened to each audio recording multiple times to ensure that I had transcribed every interview correctly. I then read through each of my interview transcripts multiple times highlighting what I believed were key words, expressions, and key thoughts. I then compared all of my fifteen transcripts and wrote down the shared words, expressions, and thoughts. Essentially, this was how I moved through the first cycle (see Appendix D) coding process.

In the second cycle, I again compared all of my interview transcript data and compressed the shared words, expressions, and key thoughts into general themes/areas. I then coded each of these themes/areas into four larger themes/areas. They are: family history, siblings and gendered caregiving, communication, and reflections.

In his discussion about analyzing phenomenological data, Moustakas (1994), states that phenomenological research can follow one of two approaches. The two approaches are the modified van Kaam method (van Kaam, 1966, 1959) and the modified Stevick-Colaizzi-Keen (Lee & Ljunberg, 2007) method. Of the two approaches, I followed Moustakas’ modified van Kaam method. Moustakas’ modified van Kaam’s seven-steps method includes: 1) Listening to
interview data, 2) Eliminating unimportant ideas or concepts as a way of promoting horizontalization or identifying lived experiences, 3) Clustering lived experiences into themes, 4) Verifying that the lived experiences of research participants have been properly captured through the thematic clustering process, 5) Using or referencing individual lived experiences – Individual Textual Descriptions - of research participants as found in transcribed interviews, 6) Outlining structural experiences – Individual Structural Descriptions – based on individual experiences of specific settings and imaginative variation of lived experiences, and 7) Creating textual-structural descriptions of lived experiences and incorporating them with themes that have been identified (Moustakas, 1994, pp. 120-137).

The phenomenological model for qualitative research is particularly effective when researching individual life experiences. As Moustakas (1994) argues,

It offers processes and methods that require effective listening and hearing, seeing things as they appear and as they are, not judging them, learning to describe experience rather than explain or analyze it, focusing on a core question and exploring in depth the everyday constituents of human experiences. (p. 175)

Like Moustakas, Pollio et al. (1997) argue that qualitative research must enlighten and not simply explain individual experiences. They state that

Well-executed qualitative procedures that do not generate meaningful results are technique without soul. Brilliant interpretation may have value, but one needs to be convinced of the evidence serving to ground such findings in lived experience. (pp. 55-56)
Chapter Three Summary

In this chapter I have argued that the optimum way to understand the lived experiences of research participants is through modified transcendental phenomenology. Utilizing semi-structured interviews, I have described the ethical issues that I comprehensively addressed when following the ethics protocol stipulated by two university research ethics boards prior to seeking-out research participants as well as prior to, during, and after the interview. Following this, I then addressed the specific challenges linked with interviewing, interview transcribing, and coding and analyzing interview data. I have shown how significant researcher reflexivity is during the transcribing, coding, and analyses process. I have discussed the significance of the audit trail, specifically the audit practices that I created and followed when I was gathering my research data. I am confident that these audit practices defend the trustworthiness/rigor of my research data. In the next four chapters, the research finding chapters, I present and discuss my data and research themes with readers. I discuss how family history, sibling relationships, gendered caregiving, and poor interpersonal communication facilitate family conflict prior to, during, and after nursing home placement. I also share some of the reflective thoughts shared by research participants on interpersonal conflict, aging, caregiving, and nursing home placement. Research participants speak to questions such as: Who am I when my older parent moves into a nursing home? How does my parent moving to a nursing home impact on my relationship with my sibling(s)? How do I manage caregiving for my older parent on my own? Why did I choose to care for my older parent? What reflective thoughts, if any, would you like to share about your family’s experience with conflict and caregiving? As indicated earlier in this chapter, my research study on conflict in families, caregiving, and nursing home placement, is based on
retrospective semi-structured interviews (see Appendix D) with fifteen women who live in both urban and rural communities in central and northwestern New Brunswick, Canada.
Chapter 4 - Data Analysis and Findings, Part I – Family History

In the previous chapter, I argued that understanding the lived experiences of qualitative research participants is best achieved by following a modified transcendental phenomenological approach. I stated that the best way to achieve this is through semi-structured interviews. I then indicated that I did this by interviewing fifteen women who live in central and northwestern New Brunswick, Canada. Through the processes of interview transcribing, coding, and reflexive data analysis, four themes emerged as the basis with which conflict in families who are faced with caring for an older family member, culminating with nursing home placement, can be understood. The four themes are: Family History – where adult children reflect back on their relationship with their sibling(s) in childhood, Siblings and Gendered Caregiving – the degree of sibling involvement with caregiving for an older parent and how it is that adult females continue to assume the majority of caregiving for an older parent, Communication – the different types of inter-sibling communication that are practiced and how these different communication practices impact on sibling relationships when caregiving for an older parent, and Reflections – the thoughts of adult caregiving daughters on their caregiving experience with an older parent. In the initial data chapter, I will discuss the impact that family history can have on adult children in relation to caregiving and non-caregiving behavior.

In their discussion on conflict, Wilmot & Hocker state that “How you handle conflict spreads to other members of your family” (2001, p. 4). Connected with family behavior, Merrill (1997) argues “… that family history plays an important role in the configuration of family caregiving” (p. 62). The idea that interpersonal conflict can occur over a lengthy period of time – the type of conflict that is definitive of older family conflicts – is underscored by Cupach & Canary (1997) when they state that “…people can experience interpersonal conflict over time,
extending the conflict episode for weeks, months, or even years” (p. 11). In this data-based chapter on family history, my research supports the arguments made by Wilmot & Hocker (2001), Cupach & Canary, and Merrill (1996). For the majority of my research participants, their own family history has had a profound impact on how they interacted with their siblings as adults, the choices that they made as caregivers, and the various interpersonal family conflicts that ensued prior to, during, and after they had placed their older parent in a nursing home. Several factors rooted in family history were underscored by interview participants. These factors are: parental favoritism, older parent expectations, adult child decision-making, sibling age gaps, and geographical distance.

Research shows, that families regularly do not address and resolve older family conflicts (Ram & Ross, 2008; Laursen et al., 2001; Hargrave & Anderson, 1992). Unresolved older family conflicts, contribute to increased family conflict as older parents approach the end of life (Kramer et al., 2006). The following excerpts taken from the interviews with research participants describe how older family conflicts, that were not comprehensively addressed, have impacted on family caregiving prior to, during, and after nursing home placement.

Louise is one of two remaining sisters. Her two other sisters died several years ago. In my interview with her she stated that the conflict that she was experiencing with her sister was one that had originally begun many years ago soon after her mother had died.

My sister, Phylis, and myself are the two remaining sisters, we are close to my father, after my mother died… my father… was… still physically well. Mentally cognitively he has been up until just very recently uh basically amazingly well … Um (pause) but, as he wanted to stay in his own home… Mmm, initially when he was in his eighties he wanted to. And when he was looking after mom he wanted to, it’s a very
very very large property on the Penobscot River. He can live on a on a single floor. Um, but… he became very lonely um uh after mum died. And he is a man who… who is, is not necessarily one that… uh although he was a financer and was very used to meeting people and was extremely well liked he is not very extroverted. And so, he.. he didn’t.. um necessarily go out and look for a partner, although his brother, uncle Milton the doctor really really tried to hook him up with a women. Um, he didn’t take too well to that although several women did, and he, he, he tended to.. stay more to himself and really didn’t want to have someone move in with him. I actually encouraged it. Um he met a very nice women in St. Lambert and um but he he didn’t seem to want to do that. My sister, Phylis, um, very much discouraged that she was just fit to be tied every time uncle Milton thought it would be a good idea that dad might go out to dinner with this lady in St Lambert. That was kind of the beginning of what appeared to be, was going to be uh what is now very a very very serious conflict and all sorts of stuff going on between my sister and I. Um, and that would be, that’s got to be 15 years ago or more…

Sarah is one of two sisters. Sarah spoke about her childhood and how her younger sister had been favored by her parents when she and her sister were growing up.

I don’t remember her being domineering but she is five, or six years younger than I am so it was sort of like, I was an only child, kind of thing. Yea, and the other thing that happened, was there was a child died in-between us… myself and her. So then, you know I suppose that’s why there is the age gap. So she is five years younger and then my younger sister, the sister that died would be two years younger than her. So,
um there’s the age gap there. So I was kind of an only child, but then when she came along, I got a little bit older, the sun kind of always rose and set on her. And um, she was, and that’s my perception and its hindsight very much my perception, she also was, perceived to be, and was very bright.

Sarah also indicated that her relationship with her sister continued to be strained into adulthood.

I think she resented perhaps what we had, rightly or wrongly. And um… maybe distanced herself from me and from my husband because of what we had. I don’t know but that might be a, a bit of what started to happen. So maybe we were never particularly close… And so, um, if you look at that whole family thing um in those, when we were in our twenties and thirties and forties it, it probably was not the greatest situation in the world. And probably not great for our parents at that time too. Their relationship with each of the three girls would have been very very different. I certainly would have been seen as the one who landed with her feet on the ground um took off was successful. Um, and…I didn’t need anything so I was pretty much ignored.

Like Sarah, Liz believes that when she, her sister, and her brother were growing up, her sister had been favored by her parents.

I don’t know, I don’t know quite what happened from the standpoint of how our relationship was then, but I know that she was definitely treated differently. She was treated differently, but I, don’t think that she and I had really much of a relationship at all.
Lenore, who is part of a very large family, spoke about how when she was growing up all of her siblings communicated as one single unit.

We grew up in a nuclear family…. so we have grown up a very tight knit family ahmm not without dissentions of course but ahh one of which mostly the … siblings, ahmm communicate kind of as one body.

She also emphasized that out of all of her siblings, her eldest sister had long since been chosen by her mother to be the family’s decision maker. It was her eldest sister who had made the decision to place her father in a nursing home.

She is the eldest and she was seen by mother, by my mother as being the one responsible and for the family in general even when we were siblings, and um I think felt the obligation in terms of making sure my father was cared for. And she she facilitated the you know whatever was positive in the nursing home, she facilitated through relationships and contacts and being present.

Isabella indicated that her brother is not a regular caregiver for her mother who now lives in a nursing home. She believes that her brother, as he always has, continues to play the role of knight in shining armor.

My brother, I think, made two appearances because that was a crisis time. So he wants to come in and be the knight in shining armor kind of thing. Ahmm, and so, you know, even after, even though she has been in the nursing home for over two years, you still see those, those dynamics, those family patterns playing out.
Bea, who has one sister and three brothers, stated that soon after her mother became ill, she took on the role of primary caregiver. She believes that her approach to caregiving for her mother is very similar to the caregiving approach that her mother had followed years earlier.

You know my mother’s mother was in a nursing home, my grandmother. When I look back on how my mother dealt with things and how I deal with things, it’s very similar. It really is.

Bea also stated that in her family, it was she who had been selected to care for her mother. Um…. I guess I was always well mum used to call me her right hand. And um… and then things started happening it was strange. It was just expected I suppose that I would be the one to take her to her doctor’s appointments. Um, it was never really discussed it was kind of like we didn’t have to. It was understood.

Linda spoke about how her father’s early death had propelled her older brother to become their family’s male decision-maker except when it came to caregiving. Conflict between her and her older brother occurred because although he refused to help care for their older mother - arguing that because he lives in a different community he could not do so - he also contributed to making caregiving very much gendered as it was Linda and not he who took care of their mother. Her eldest brother was unsupportive and critical of her caregiving.

The oldest, um, took it upon himself to um, how do I say this. Dad died young. I was ten. He would have been…. 14 or so 13. And people would tell him you have to take over now as the man of the family. And so, he, he took that responsibility upon himself so as we get older we find that all those old family dynamics when the, an
aging parents becomes ill. Umm, so the care goes to me automatically it seems. But he still feels like well he should be calling the shots. Unfortunately he is not always here to see what goes on. Um, so um, I don’t want to put him in a bad light because really this is really his perceptive on things. I am basically talking from my perspective. As a caregiver, as the daughter, as the oldest daughter actually. So um, there were times when the conflict was um we misunderstood.

Linda’s younger brother, who also lives in a different community than she and their mother, was favored by their mother when they were growing-up. He was also equally critical of the caregiving decisions she made for their mother, and especially critical of her decision to place their mother in a nursing home.

My younger brother, he lives in Bangor. He was a little more attached to mom than the rest of us not to say that we weren’t but he was, because the dynamics there, she was somewhat protective of him and therefore you know, that’s how it goes. When I, I’m going to say it the way he told me… when I put her in the home, well sorry, I stuck her in a hole where she is going to die alone and in the dark… and that couldn’t be any further from the truth. Because when she was at home she was alone. Uh, in a hole, I don’t think so. It was newly renovated, the people there were wonderful they had become like a secondary family. Um, I knew all the workers by their first names if not their last names as well. We were very comfortable together, like they kept me very well informed and mum was happy there.

She describes a third brother as being someone who has always been neutral. This brother, as he has always done, stays away from conflict. He has not and is not critical of the caregiving that she provides for their mother.
I have another brother by the way, who is older than me that is between the oldest
and myself, and he is in Millinocket. And he is fairly neutral, like he supports me but
he doesn’t help me you know what I mean. Um, he is in Millinocket what can he do.
I feel like well you can call me and see how it’s going but he doesn’t. But he never
did so. I call him neutral. Um, the others didn’t really have much of a reaction I
guess it was expected that the oldest would take on the responsibility. Just like
things were when we were younger
Chapter 5 – Data Analysis and Findings, Part II – Siblings and Gendered Caregiving

Distinct from other relationships, sibling relationships can be quite complex (McPherson, 2004). As stated earlier, they are often seen as obligatory and may survive longer than other types of relationships (Mikkelsen, 2004; Laursen et al., 2001). In addition to this, Silverstein et al. (2008) state that “while it is reasonable to assume that siblings share somewhat similar attitudes toward filial duty as a result of having been raised in common home environments, it is also likely that siblings differ based on their unique experiences and social characteristics” (p.74). Mikkelsen (2006) argues that sibling relationships “…can be a source of joy and support or frustration and hostility” (p. 35). By far the largest amount of the data that I gathered through my interviews focused on how difficult and even fractured sibling relationships became as a result of caregiving for an older parent that eventually culminated with nursing home placement. In their discussion on conflict and interpersonal relationships, Wilmot and Hocker (2001) state that

Conflicts move from episode to episode in a continually unfolding pattern of interaction between the prime parties. The moves and interpretations of each party influence those of the others. (p. 48)

Folger et al. (2001) argue that in situations where conflict is spiraling out of control or escalating, disputing parties may attempt to keep conflict private and contained within the family unit.

Conflicts may also be hard to understand due to conscious efforts by some parties to keep the conflict “hidden” – out of the more public forums …

(p. 23)
Interpersonal conflict is truly very emotional (Weeks, 1992) and very stressful (Gottlieb, 1997; Pearlin, 1989). Human emotions and stress are intensified when disputing parties become entrenched in their positions (Bar-Tal, 2002). In many of the interviews, it is evident that siblings adopted opposing views as to how best to care for their older parent. Conflicts between siblings erupted and sibling relationships were compromised. In their interviews, research participants described their conflict situations using a combination of what Cupach & Canary (1997) term analytical remarks. The remarks that they shared were (nonevaluative remarks), confrontational remarks (critical remarks), and conciliatory remarks (remarks that offer some sort of concession) when describing their siblings’ involvement with caregiving.

When interviewing Louise, it was apparent that the conflict that she had experienced with her sister had escalated to the point where she had sought legal advice and actively avoided all contact with her.

I hired a lawyer about two years ago, just simply to tell me what to do or what not to do and basically she told me to keep my mouth shut and basically to not say anything to her or really have any contact with her. Yes, um, just so that I won’t do something wrong. Um, and so we have, almost no contact. And any contact that I have with her, for instance if an email comes in to me, in the last 18 months, um, I have been keeping a word document in my computer and I have every last email that has come, that has been sent to me, from her, and anything that I have sent to her. I’ve got it in a document. That may or may not ever be used for anything I have no idea. Any phone call that has been made I have a record of it, what time it came in and sort of a summary of what has been said.
She views her relationship with her sister as toxic and not worthwhile to maintain. Louise believes that it is much more important for her to move forward with her life then being bogged-down with sibling conflict.

Oh I will and I won’t, I am not going to win anyway, there’s no way I can there is just no way I can ever like achieve anything and so, yea, yea, um, it’s just this reduce the conflict as much as I can. It’s a toxic relationship and I have just got to reduce it and carry on with my life.

Louise described how her sister initiated informal home care for their father.

So my sister decided to higher um a care giver, for two hours a day or however it started I cannot remember. She talked to dad, because again dad was at that point, extremely competent. And um more than, I mean more than he was capable of saying well okay, Phylis, if you think that I need somebody to come in and get a meal at dinner time and clean up some dishes from breakfast and lunch then that is okay. So no, at first I was no consulted at all.

She states that her sister is very controlling.

Her whole life, her whole entire life revolves around… um my father. And… and the conversation goes, that you know, what is going to happen when he dies, and she she can’t control everything. Yeah. About my father, because that’s really all she has.

Yvonne, who did not want her mother moved into a nursing home, but rather preferred that she remain in her own home with informal home support care, does not believe that her opinion mattered at all to her siblings. They all wanted their mother moved
to a nursing home. For Yvonne, avoiding confrontation with her siblings was the best option.

I didn’t want to engage in that argument because I knew there would be no hearing of an alternative perspective.

For Yvonne, a way for her to regain control and facilitate the type of caregiving that she envisioned for her mother was simply to go and do it.

So then the circus started and primarily it was left up to me, I have another sister in Fort Fairfield and um another sister in Houlton. Um, one is younger than me one is older than me. I am right in the middle. I have middle child syndrome, so um it seemed to be up to me to um… kind of decide where we were going to go with this.

Lenore, who like Yvonne did not want her mother moved to a nursing home, was very angry that that option had not been fully explored. She believed that in her family conflict had escalated because of the mindset or paradigm that existed between herself and her siblings.

… some people are very black and white thinkers, this should be this and this should be that. Now you don’t there’s no, it’s very logical at this persons age that they should be in a nursing home. Its seems to be that kind of thinking. And why would you disagree. Mmm, and if you disagree with that you must not be thinking of their care. Well it’s a whole different paradigm that I am working with …

Lenore stated that her siblings had approached their mother in an overly clinical way. This angered both her and one of her parent’s home caregivers. Lenore believed that her siblings had not considered every caregiving option.
Now, well, I was talking about my other family members my brother and my two siblings, the two younger sisters, the nurses, they immediately wanted my mother in a nursing home. As my brother did who is a social worker. And they thought very much from the medical perspective. She is at a certain age, she cannot care for herself. She should be in a nursing home. And I really do think it’s the older thinking. I really do think that that the care that was just provided at home is sufficiently or better than what can be provided institutionally. And even cost wise there is advantages. And, um, the care provider. One of the care providers when I spoke with her, she had had been the care provider for my father, as well as a care provider for my mother and she she was quite angry to see that my mother would have to go into a nursing home you know because she saw what she had.

Susan stated that when her adult daughter attempted to speak with her elderly father about the possibility of his moving into a nursing home he said that he did not want to move because Susan’s sister would not approve.

And, um, the reply she got, which I have also received, and this is parroting, you can just hear the words coming from my sister, oh well, you know, I, Gloria knows how much I love to sit and look at the river and she knows that I really like it here, and she knows that the caregivers that I have really like to come and and look after me, so, no, I am really very happy here.

Susan also stated that the escalation of the conflict with her sister, Gloria, would make it difficult to celebrate their father’s 85th birthday. She would have to pretend that nothing was going on.
Yep Yep, there really and on top of it all, there is a 85th birthday and Gloria is planning a party which apparently is going include, she is going to invite the whole of Sherbrooke which is going to include like about 200 people. So there’s going to be a facade of some sort or other, where I, and some other family members are going to have to come to this party and look all happy, and let on that there is nothing going on.

Susan justified the escalation in conflict with her sister by arguing that Gloria was unstable. In the bits of pieces that we know about her, we actually wonder if she has got a personality disorder. But she is certainly two people, I mean there is no question that she, um she has, um like she functions as two people.

Similar to Louise, Susan underscored the idea that conflict was spiraling out of control when she said:

So like the, my children have become involved. Yep, umm, so it has dragged the whole family into it.

Laura spoke about how geographical distance facilitated conflict. She lived close to her mother, while most of her siblings lived away. They did not experience the progression of their mother’s illness as she had.

There was family conflict in there because the ones who were away from home didn’t experience the stages that mum was going through and they would they would come on a visit they would come on a visit and then there was a major panic and it was a major we’ve got to make decisions and we just changed things here and and
mum’s like well this is working fine and I’m thinking that it’s working okay and the caregivers are happy …

Laura believed that one way that she could explain why her younger siblings were so adamant that their mother be moved into a nursing home was because of difference in age. She, as one of the older siblings, viewed her mother’s aging process differently than her younger siblings did.

I’m older and I’m starting to look at retirement myself and aging and that kind of thing so so ah I think that there’s a lot to learn. I’ve got this spectrum with mum that you ask her you don’t tell them and that you you talk to them and you know you sort move along gently and then there’s the younger ones in the family who just come along and say look you just pack up and we’re going to move you. I think it was a, I think that was a generational gap ah somewhat because we’re all brought up by the same parents so it wasn’t our upbringing it had to be age it had to the differences in in the ages.

She stated that caregiving for both of her parents was just something that she automatically did. She did not think that there was any other option.

So, so, ahmm, I just started by just doing what had to be done.

After already having had spent many years taking care of their father, until his death, Laura was tired of being criticized for her caregiving work. She stated that in one conversation that she had had with one of her younger brothers that she welcomed greater sibling participation.

I just said to my brother you know when I’m through this, six years, I’m going to take a break and somebody else can take the lead in taking care of mum.
Ellen, who had been the primary caregiver for her mother, recalled an informal family conference that she had taken part in. She and her siblings had gathered to discuss how best to take care of their mother. She remembered feeling personally attacked for the caregiving that she had provided. Ellen attempted to understand her sibling’s behavior by saying to herself that they did not really know how she had cared for their mother.

I thought ohys, you know, this is kind of like getting beat-up with an egg beater, but, ahah, but I also knew that that they just didn’t understand and so I thought I’m just not going to take offence at all of this stuff I’m just going let things unfold.

Rose also spoke about how her siblings had been completely unwilling to help her care for their mother.

I figured that if I could do it every weekend they could do it once every six weeks. And it got to the point where I just stopped asking. Because it just took too much energy to ask to be turned down to get disappointed and then we feel resentful, so just never mind, I will just do it myself thanks. You know. Just get out of the way.

I was so busy looking after mom that I never thought about my siblings you know uh maybe I anticipated cooperation, collaboration and it was a surprise when I didn’t get it. Um I don’t know.

Rose has stopped asking her siblings for their assistance and focuses solely on the care that she provides for her mother.

… it has come to that point um what happens next, I can see her continuing to decline. My siblings continuing to make excuses and I'm just going to continue to visit her as often as a can.
In the past, Rose would occasionally organize family gatherings at her home and bring her mother to her home so that her siblings could visit with her there as they did not visit her mother in the nursing home. She states that she will no longer facilitate that type of visiting arrangement.

So um my siblings are probably going to see her less frequently, not that it was frequent, but I mean if they want to see her now they are going to have to go to the nursing home rather than coming to Rose’s house.

Like former President Ronald Regan, Rose’s mother has Alzheimer’s Disease and so her mother’s illness has been a lengthy one. Given the long time that her mother has been ill, she resents that her siblings have not participated more.

I think it was Nancy Regan, Ronald Regan’s wife, who said the long goodbye. And that’s what it is. And as far as my family members go, as I’ve said, I do feel resentful sometimes.

Prior to her mother’s move into a nursing home, Ester took care of her mother in her mother’s home. Ester’s family believed that she was spending too much time caring for their mother and this was contributing to conflict between her and her siblings.

I didn’t, ahm, want to leave her alone nights and the other siblings thought that I was babying her and that she was ah playing on my emotions you know, in wanting me to be there nights, she would have what I call anxiety attacks and ah she would have them in the middle of the night and call me to come over.

Ester is disappointed that her siblings did not do more to facilitate home care so that her mother could live in her home longer than she did.
People are not on the same page, two or three children in the family have left the nest, they have all pursued their own life path, and they all bring different wants, needs and issues to the table. And um my situation, I love my brothers and sisters, they are great, but it shocked the hell out of me that they didn’t give me more support and input in trying to see that our mother remained at her place a little bit longer.

Gendered Caregiving

It is no consequence that all of the individuals who I interviewed were women. As I discussed at great length in Chapter Two, extensive research supports the argument that "in practice, daughters are more likely than sons to care for parents and to provide a wider range of help under an array of circumstances" (Connidis, 2010, p. 161). Women take on the role of caregiving for an older parent, as this has traditionally been seen as “women’s work” (Matthews, 2002, p. 17). I also believe that caregiving for older family members continues to be defined as women’s work because some older family members believe that only women can truly provide the kind of care that they want. Many of the women who spoke with me described how their caregiving “work” had placed them in conflict with their male sibling(s).

Out of all of my interviews, my interview with Linda really underscored just how difficult caregiving had become as a result of the fact that her brothers’ unequivocally refused to participate in caring for their mother and facilitating their mother’s eventual move into a nursing home. Her eldest brother was particularly critical of her.

Um, and so one of my brothers did not like the idea of my making these decisions without him. And he felt that when I sold the house I didn’t follow protocol and things like that. And it was really hard on me, because I was just doing the best I could and both for mom and myself. Because I had to keep my head above water too.
And well he, he wasn’t calling the shots so he wasn’t pleased. But, um, eventually he came around and he realized that well okay we actually got more for the house than the second real estate agent was willing to start. So at the end of that story I did good. And um it was hard for him to admit it but I did. And I think a lot of it has to do also with me being younger than him and being a girl… You know when he moved on I continued to grow up and he didn’t see me continue to grow up. So it was almost like he didn’t think I could do it. And… caring for an ageing parent is more than just making an occasional meal for her. Going to help her clean the house. There is a lot of banking, a lot of paperwork a lot of legal issues that needs to get done. So I had to take care, over all of that stuff on her behalf. And he didn’t see that. He didn’t realize that I was that I had become capable if I wasn’t before…

Linda viewed conflict and conflict escalation as something that was not only mitigated by the lack of caregiving participation on the part of her brothers, but it was also something that had become multigenerational. Her brother’s children were unwilling to help care for their grandmother.

Ohh there were lots of little family arguments. Most of them in the evening, you know, in front of the TV, turn the TV off this is has to be addressed, we have got to talk about this come on fellers you know this is not rocket science, this is what we are up against… and uh one brother was single, uh but had a job whereby it was shift work. And um the other two brothers were um pretty much tied down to their jobs, but it was their children that I was looking for the help from. Um you know, they were late teenagers, were up here at university and they could have assisted for a couple of years. And so um kind of walls went up and you didn’t talk about it. And
I would always say, okay um you know mum’s being discharged pretty soon. We got to get onto this, what’s going to happen. And I just felt that I was beating my head against a brick wall because there seemed to be no room for any negotiation.

Linda experienced even more anger after her mother had moved into a nursing home.

And what really irritates me, is if I go over to the nursing home to see my mom then that lets the boys off the hook, oh well Linda has just been there so we don’t have to go see mom. But why can’t you go see mom tomorrow. You know, it’s okay for her to have three consecutive days of visitors. But no, if I’ve been there, then they don’t have to, they don’t have to go see her. Um, it’s just discouraging. You know and that, it’s our mother, you know it’s your grandmother, can you not help?

Linda, stated that conflict escalation in her family had side-tracked their ability to reach a caregiving solution.

I have many girlfriends, who have been down the road with their ageing parents, and they are the only child, so the decisions are entirely up to them, and I think oh my God that must be so easy. Mom this is where you are going? Dad this is what we have to do? There’s no… you know… running it through anybody else’s hair, bouncing ideas off anybody. If you’re an only child and your parents are in this situation, you are the only decision maker. However, they would look at it and say I wish I had someone to share this burden with, mhm, you know you’ve got brothers, um surely you can you know get on to this and get something worked out. Mmm, but not in our case, um some families could work it out really well, others, we just couldn’t come to an agreement because of too much conflict.
Linda also attempted to come to terms with her brothers’ absentee caregiving by appealing to the idea that they too were going through their own grieving.

I… I wish… families would realize. That the caregiver is so burdened that for them to add to that burden is just mean. I know they don’t do it deliberately. But I think we need to raise awareness. That the caregiver has enough and don’t add to it. Provide support instead. There was a time where I didn’t get support, but the opposite and that was really difficult, but things are better now. I just want to say that and I understand now that it wasn’t personal. They were going through the stages of loss and that it was a very human reaction. Unfortunately I was the one that was targeted because I was the caregiver.

Finally, Linda spoke about why she willingly assumed the role of primary caregiver both before and after her mother moved into a nursing home. She believes that because she is the daughter, there are things that her brothers simply cannot be involved with when it comes to caring for their mother.

Um, if you go to the records, then my brothers are listed as the people to call on the file. So that’s all settled and then I’m the daughter and let’s face it, um, sons are not daughters, and um it might be different, probably would be totally different if it was, if it was sons putting their dad in a nursing home. I’d be the odd man out. But it has been difficult because they are the sons, but they are very good, they are there, my brothers for emergencies, can you come up right now, or your mother needs new pajamas, they will do all that but they are not a daughter and so I am going, as I say now, it is probably every other week, I am going all the time and you know, she
needs face cream, or she needs new undies, or new nighties, and that’s just something the boys don’t get involved in.

Isabella did not believe that her brother was doing enough to care for her mother. Conflict escalated when she witnessed her brother refusing to be a caregiver. Isabella was angered that her brother had turned all of their mother’s caregiving over to her.

…my brother has been absent from pretty much everything that has to do with my mother and her care, uhmm, he wants nothing, he wants as little as possible to do with it and I’m not certain if that’s, I can’t tell you how come. I really wish I could tell you, I wish I had an answer for my brother’s behavior, but I don’t. Isabella desperately wanted a bit of a break from caregiving and so she appealed to her brother for some support.

I can remember calling my brother and saying, Owen, look, could you go, could you give me a day, a Sunday off, and come up and visit with them? He wouldn’t do it. He just wouldn’t do it. He didn’t want to do it. He didn’t think he had to do it.

Without any caregiving support from her brother, like Louise, who had stopped speaking with her sister, for a period Isabella also stopped speaking with her brother.

Ahmm, and, and, so, it got to a point where there was a year where I didn’t speak to my brother because he, he, refused to help out with my parents. So he, he, has only shown up for the big moments, right, the crisis moments, but he’s never, he’s never participated other than that.
Isabella recognizes that her role as primary caregiver for her mother is largely based on her gender. However, she truly wants to care for their mother. She does not help out of a sense of duty.

Ahmm, and I have a funny feeling that one of reasons the majority of responsibility has fallen to me is because I am the oldest and I am a girl. Ahmm, and, there are times that I really resent that. Not because I do not want to do it. The thing is, when it comes to my mother, there is nothing I wouldn’t do and I don’t do it out of a sense of obligation.

Margaret also spoke about the gendered nature of being a caregiver. Like Isabella’s brother, Margaret’s brother does not actively participate in caring for their mother. I have a lot of anger towards my brother and it has caused significant conflict in our family. You know, my brother wanted to have a say about, about my mother’s nursing home placement, but he never showed up for the family meeting, for the family conference with the doctor, he never showed up for anything, but yet he still felt he should have a say. And these are conflicts that we are still dealing with today. Ahmm, my mother has been in the nursing home 3 years in September. I can count on one hand the number of times Jack has been there. Ahmm, he never calls her. Never, nothing …

When speaking with Flavia and Bea each stated that they felt angered by their brothers for not being more involved as caregivers. Their statements further supports that caregiving is extremely gendered and that this inequity contributes to sibling conflict.
Flavia stated that she had envisioned that caregiving would have been shared between herself and her brothers.

In terms of expectations I think, expectations, ahmm, in that things would be divided equally among us, the responsibilities, and the visiting, and all that kind of stuff, but that hasn’t been the case at all. I do most of it.

Flavia also stated that in spite of the fact that her brothers did not participate in caring for their mother, they were angry at her because they believed that she had “stuck” their mother in a nursing home.

It was personal they were blaming me as if I had the power to make mum sick. Everything was my fault… everything was like. Whatever! You stuck mom in the home and she is not as sick as you say she is and my other brother well it was anger. You know and as long as mom, as long. Well they would lash out at me.

Bea compared herself to a character that had been part of a late 1970s – mid 1980s American sitcom television show.

Sometimes I feel like, you know, that show Love Boat. They have that girl and she was the cruise director, that’s what I feel like in my family. I’m the cruise director. I have a lot of anger towards my brothers and it has caused significant conflict in our family.

She spoke about how she had finally accepted the fact that her brothers were unwilling to help take care of their mother. She had given up asking them for some support and focused instead on doing the best that she could as her mother’s primary caregiver.
Never, nothing. I feel, I feel like I have to shame them in to doing what they should be doing anyway. So, I don’t, I don’t see like in terms of the future, things changing from where they are now. I really don’t. I don’t know what’s going to happen with my brothers and I. At one point we were very very close, ahmm, but we have become very different people and I am very angry, still, about their self-absorbedness and selfishness, ah, and unwillingness to to even pick up the phone and call my mother. I just don’t get it and I don’t imagine I ever will and so, you know, I can’t imagine that that’s going to change. So, I suspect that we will continue the way we are. I am doing the best I can for my mother because she always did the best that she could for me. I just wish that my brothers would remember all the things she’s done for them. I don’t know how they live with themselves. I, I, I can’t even understand it. Maybe I never will.
Chapter 6 – Data Analysis and Findings, Part III – Communication

Research shows, that in the work environment enhanced communication has proven to improve business practices and increase employee job satisfaction (Hynes, 2012; Bambacas & Patrickson, 2008; Van den Hooff & de Ridder, 2004; Tucker et al., 1995). Comprehensive communication is thus effective in relation to problem solving (Katz et al., 2011). In the research on the origin of interpersonal communication, it is argued that families are the initial facilitators of interpersonal communication (Caughlin et al., 2011). It has been stated that “the way family members relate in the family context (communication and interaction style) predicts relationship quality” (Clarke et al., 1999, p. 269). Additional research in the area of families and nursing home placement has shown that there are huge benefits associated with improved nursing home staff communication with residents and their families (Majerovitz et al., 2009, Pillemer et al., 2003; Pillemer et al., 1998). Nursing home staff, residents, and their families are better able to problem-solve and this then enriches nursing home culture. In her discussion about communication, Tannen (2000) states that:

We all talk about others in ways we would not talk about them if they were present.

That’s not evil; it’s human. We have made the decision not to hurt their feelings when we refrain from making the hurtful remarks directly to them, and we are trusting the people we are talking to not to repeat what we said to the people we’re talking about. (p. 35)

In other instances, communication between family members may indeed be much more direct. Caughlin et al. (2011) argue that for some families
Greater intimacy is associated with more conflict because it leads to greater
directness in communication, an increased sense that one has the right to make
requests of the other, and increased expectations that the other will comply with
one’s request. (2011, p. 686)

When listening to research participants, it became apparent to me that one of the key reasons
why conflict between siblings occurred was because some siblings were simply not interested in
communicating. Other siblings actively avoided inter-sibling communication as a way of
lowering personal discomfort. In another family scenario, one sibling wanted to control what
was said and consequently this contributed to making the other sibling feel psychologically
isolated from their older parent. Some siblings were too busy with their own lives to bother to
communicate. In one family where inter-sibling communication had broken-down
communication intervention was sought out culminating with positive results where the siblings
were able to communicate with each other again. In another family where one sibling had
attempted to communicate with her other siblings about caregiving expectations, nursing home
selection and placement, and the post-placement nursing home visitation schedule, her siblings
simply chose not to hear them and consequently they did not act at all. Finally, one research
participant stated that while she believed that inter-sibling communication was a critical aspect
of caregiving for an older parent, equally important was acting on what had been communicated.
Inter-sibling communication was itself not enough. Of greater importance was acting and
assisting her older mother. The following statements show how lack of communication
contributed to inter-sibling conflict.

Lenore resented and was angry that her eldest sister had been so aggressive in
communicating to her that she had made the unilateral decision to place their mother in a nursing
home. She confided this to her mother’s paid informal caregiver who encouraged Lenore to speak-out.

It’s just I think that people come from their dominant places you know. Mmm. Yeah. And their dominant places of perspective or you know, and uh so to bring another voice in. I remember I had, I had this emotion when I first heard from my eldest sister, this anger and emotion you know and I held it and then I called interestingly no family member, I called the caregiver the next morning and I spoke with her and I said you I know I’m mad, you understand. She said, well have you shared this? I said no and she said why haven’t you shared this? You are a family member you deserve to have a voice. You should speak.

Lenore also stated that the she did not communicate with her eldest that she favored informal home care over nursing home care because her siblings had made it known that none of them supported informal home care over formal nursing home care.

I didn’t want to engage in that conversation because I knew there would be no hearing of an alternative perspective.

Lenore
So I would say that I’m reconciled. Um and I’m also still aware that that in terms of my own life... we need we need many voices to help us in discernment. You know And not just, and they should maybe be present early, cus you know you need to hear from the black and white, you need to hear from the other, you need other professions other experience to get a full picture of what all the other factors may be in a decision. So that might help.
Louise’s need to avoid any contact with her sister, Phylis, has involved her husband and her adult children in the conflict that she has experienced with her sister. They block all communication that comes from Phylis. Louise stated that

If it is possible for me to not have contact with her, like in other words if my husband can do it instead of me, mhm, and um uh then he does it. And uh our children, uh, who live in Charlottetown, um we and we were out there at Christmas. Ah, if she made a call to their house when I was there then they would say I was out. Um, I don’t know whether she believed it or not, didn’t matter, but um.

Louise spoke about how her adult attempted to ask her father if he was really happy living at home and not in the nursing home.

Um my, my daughter, a school teacher, and a very very caring kid, um spoke to him [her daughter spoke with her grandfather, Louise’s father] on the QT about… about… 10 years ago maybe, because the the whole family has seen what has been happening here. She said what would you like to do? What would you like to do? Do you want to stay here, [Louise’s father is still living in his home] or would you like to go somewhere else? Would you like to go into a home [a nursing home] where there are other people? Um, and then those two home care hours, or those three hours whatever they were, um and this would probably be… 100 now… be probably 12 or 14 years ago or more, maybe 15, 16, 17 years ago, so he would have been maybe 85 at the time. Mmm, those caregiver hours which started then have now turned into 24/7.

Louise does not believe that she can talk with too many people about her sister’s controlling caregiving behavior over their father because if she did no one would believe
her as people who live in the community see her sister as someone who can absolutely do no wrong.

I do feel very isolated and I am very limited in who I can talk to, because um anybody in Presque Isle thinks the sun rises and sets on my sister so I, I really cannot talk to anyone.

Louise only speaks about the conflict that she has with her sister about caring for their father to a few good friends.

I blab on about this and a few close friends that know about this it’s, you know it calms me down a little bit more for you know the next time that I come face to face with her or whatever so.

Susan tried to communicate to her family that she needed assistance from them prior to moving her mother into a nursing home. No family member really paid any attention to her.

Everybody’s busy today, I know that, but you know, a group effort, kind of minimizes the workload for everybody.

Susan took the initiative where her siblings were concerned and attempted to get everyone to talk about their mother’s caregiving needs.

I just seemed to be putting so much time and effort and energy into it, and I just thought this is going nowhere, and it was only when I bought it up and wanted to address it and talk about it that it even got out in the open.

Laura spoke about the advantages of reading about caregiving for an older parent and also about the benefits of third party counseling.
My advise to people would be read read the books cause I think that that helped I think it helped ah ah you know get through and we had really that and counseling have somebody outside the family sit down with the whole family and and ah let the whole family sort of work it out.

Laura also stated that her siblings, especially those who lived in other communities than where she and her older mother lived in, would say that they thought that their mother should immediately move into a nursing home. She did not agree with their assessment as she was the one who had regular daily personal contact with their mother.

… but there was talk, there was talk about Mum having to go into a home and so, you know, they give us some, I’d bargain, well give me two more weeks, you know.

Laura spoke about how finally talking with all of her siblings about their mother’s care actually produced a positive end result.

The key was getting us all on the same wave length when no matter what it was. If you could all sit down and talk, you know we pretty well agreed, you know once it, ah once it came down as long as it wasn’t one person who was just going to it was just going to be this way or no way José then you’ve got trouble. There were strong opinions in our family but in the end basically everybody wanted what was good for Mum so so we got through it

Isabella regretted that her family had not communicated more with each other about her mother’s deteriorating health and caregiving needs. She also emphasized that for one to be an effective caregiver, it is not enough to simply talk. One also has to do.

Ahmm, so I, you know, I think that, conflict, in my, in our example, in my family, the conflict has occurred as a result of expectations. Ahmm, and I think, you know,
had we been, had we been a bit more proactive, we could have sat down as a family
and said okay this is what is going on with mum and what do we think we should do
if there had of been an opportunity to outline what, what people expected of one
another, that maybe we could have avoided some of this conflict, but again it’s the
difference between what people say they are going to do and what they actually do.
So, I just wish that, that the expectations had been outlined. That we had been more
proactive than we were because, I mean, the signs were there, right, seeing my
mother’s sort of deterioration over a period of 5 years. The signs were there. I don’t
know, maybe I just didn’t want to see them. Maybe I just didn’t want to accept that
my mother was going to be in a nursing home.

Liz really believes that nursing home staff should communicate more freely with the resident’s
family beginning when the resident moves into the nursing home.

When the patient arrives in the nursing home, I wish that there was more attention
given, given to the caregiver in terms of just a little easy get to get meetings where
they talk to you and not not lay down the rules of the nursing home, which you don’t
need to hear, your common sense tells you that. But just to say well maybe this is
maybe without the person, without the patient there this is how we see it it, and this
is how we are doing.
As part of the interview discussion, near the end of each of the interviews, I asked research participants if they cared to share any reflective thoughts about their experience with family conflict, caregiving for their older parent, and caregiving before, during, and after nursing home placement. The thoughts that were shared were: the importance of not being so naïve when a parent becomes old, caregiving for an older parent can be a retirement goal for adult children, caregiving is a very emotional experience, the importance of educating the family about aging and caregiving and how being proactive when caring for an older parent may help reduce family conflict. The following are the reflective statements that were shared by research participants. These statements support the claim that caregiving, conflict, and nursing home placement is intensely emotional and demanding work. In their research, Simpson & Acton (2013) state that “emotion work is a part of family work…” (p.52). Certainly every research participant underscored this idea in their interview.

Flavia spoke about her need to reclaim her former view about life.

Um, I, I was accused of most of my life of having rose colored glasses. Well I got them off. I really need them back, so I don’t have that feeling. I just feel bad all the time, and sad, yea, and sad and bad I guess, and anxious.

Laura spoke about caregiving as a retirement objective that she and her husband had long-since decided that they would follow.

We sort of made it a goal of our lives that when we retired our jobs were going to be to take care of our parents cause that’s what we would do.
Susan voiced how difficult it was to care for her mother, and how disappointed she was with the rest of her family.

But it, uh, doesn’t come up a lot now but I have not forgotten how difficult it was and um and it it does it just makes you, I guess the best word is your disappointed in your family.

Linda expected greater caregiving participation from all of her siblings, but was satisfied that even though they did not do this she had followed through and had indeed helped her mother and for this she believed that she would not feel guilty for not doing more after her mother dies.

I was so busy looking after mom that I never thought about my siblings, you know, uh, maybe I anticipated cooperation, collaboration and it was a surprise when I didn’t get it. I know that when we do finally lay her to rest I won’t have any regrets. And all of this guilt that I feel now I'm expecting or hoping that I'm not going to be feeling that guilt when we say goodbye to her.

Lenore focused on the meaning of love and her relationship with her mother.

What is the primary thing that you don’t want to lose, which is your love, love and that comes in relationships so that’s still present, so those she may lose all of her furniture and may lose her clothes and may lose her jewelry and lose all these things, love and relationships that are still there to the extent that they are still able to come and be present, so that was consolation in that.
Ester believed that her mother and her family was receiving quality care from nursing home staff.

Staff members are very sensitive to the families. Not just to the individual. I mean the individual’s the most important of course. Because it’s their needs and that’s why they are there.

Laura believes that support and not criticism would better facilitate caregiving. So be there and be supportive and try not to be critical and whatever but it’s it’s tricky it’s tricky and I’m sure were gonna were probably going to have conflict.

For Ellen, educating oneself and family counseling would have better for her and her family.

My advise to people would be read read the books cause I think that that helped, I think it helped, ah, ah you know get through and we had really that and counseling have somebody outside the family sit down with the whole family and and ah let the whole family sort of work it out.

Like Isabella, Margaret wished that her family had been more proactive in planning for caregiving.

Ahm, so I, you know, I think that, conflict, in my, in our example, in my family, the conflict has occurred as a result of expectations. Ahm, and I think, you know, had we been, had we been a bit more proactive, we could have sat down as a family and said okay this is what is going on with mum and what do we think we should do.
Yvonne believed that greater caregiving role clarity in her family could have helped them better address conflict.

If there had of been an opportunity to outline what, what people expected of one another, that maybe we could have avoided some of this conflict, but again it’s the difference between what people say they are going to do and what they actually do.

Chapters Four, Five, Six, Seven Summary

To conclude, in the previous four chapters, I have shown how family history, siblings and gendered caregiving, communication, and reflections are significant general themes when explaining conflict as it occurs in families when caregiving for an older parent prior to, during, and after nursing home placement. My research supports existing research presented and extensively discussed in chapters one and two and demonstrates that aging families, nursing homes, and government have not done nearly enough to comprehensively assist and thereby address conflict in families who are faced with caregiving for an older family member. In the next chapter, the concluding chapter, I discuss the contributions of my research, the limitations of my study, and present recommendations for future research.
Chapter 8 – Discussion

At the beginning of this study, I introduced and discussed the issue of aging. Statistical data shows that in both in the United States and in Canada the population is becoming older. As part of this shift, increasingly aging individuals – in particular baby boomers – are looking to other formal care options as an alternative to the traditional medical model for nursing home care. Options such as the Eden Alternative, the Pioneer Network, and the Greenhouse Model are said to be much more inclusive and resident-driven. In chapter one, I also argued that in spite of the general difference in healthcare delivery in the United States and Canada, when it concerns nursing home care there is much more similarity in both countries than we assume there to be. In both the United States and in Canada nursing home residents are expected to pay for their nursing home care when they can which for some creates a situation of severe financial burden.

In chapters one and two, I underscored the idea that conflict is an unavoidable aspect of interpersonal relationships. In their research on interpersonal conflict, Sillars & Wilmot (1994) argue that “conflict is an affliction common to all of us, however, the ways that people “struggle” with one another are quite diverse” (p. 163). White & Klein (2008) argue that in the Western world “conflict has variously been defined as disagreement, clashes, and discordance in interests” (p. 185). Conflict is thus usually seen as something that contributes to much disagreement as well as something that facilitates great harm. Research has shown that “interpersonal conflict also affects how well the body resists disease” (Canary et al., 2013, p. 166).

In a journal article on family conflict published in the early 1970s, Sprey argued “that the family process per se is conceived of as a continuous confrontation between participants with
Conflicting – though not necessarily opposing – interests in their shared fate (1971, p. 722). Conflict in families, just like conflict in other areas of human social life, is thus something that occurs on a regular basis (Sillars et al., 2004; Shantz & Hartup, 1992). In their research on adult children caring for elderly parents, Johnson & Bursk (1977) argue that in the Western world “there is no socialization mechanism available for aiding elderly parents or adult children with their new roles at this stage of life” (p. 90). To compound this problem, “…families that have never worked as a team may be unable to form networks as adults” (Merrill, 1997, p. 51). These statements strongly support the claim that in families where conflict occurs in connection with caregiving, there is little hope that interpersonal animosity can be overcome. In these families, family members have simply lost their ability to interact with one another in a harmonious way. They have lost what Katz et al. (2011) term as rapport. When defined,

Rapport is a process of establishing a relationship of trust, harmony, affinity, or accord with another – a state of special responsiveness. It is a relationship typified by cooperation, agreement, and alignment. (p. 10)

In my study, I contend that with skilled family intervention, the active participation of nursing homes, and the development and implementation of specific government policies and services, family conflict as it develops in connection with aging and caring for family members can be overcome. For families who are experiencing this type of conflict the situation is not hopeless.

In 2014, we have yet to thoroughly address the various demands associated with aging and caregiving – including moving an older family member into a nursing home. It is not surprising that the demand associated with caregiving in aging families has not been more
thoroughly discussed, as “…a demand can be viewed as a threat or a challenge to the family’s existing homeostatic functioning” (Patterson, 1988, p. 210). Families may not necessarily look forward to change. Older families have different needs than middle-aged and young families do. Because of this, we have failed to comprehensively address and potentially resolve family conflicts that occur before, during, and after nursing home placement. One of the reasons why this has happened is because “conflicts in later-life families are often perceived as relatively unimportant, particularly when compared to levels of conflict reported earlier in the family life course …” (Clarke et al., 1999; p. 261). Family conflict, such as conflict between parents and adolescent children (Adams & Laursen, 2007), or conflict in stepfamilies (Coleman & Ganong, 1987) have taken precedence over the conflicts that are of specific concern to older families.

For some families, the experience of placing an older parent in a nursing home is positive as “…nursing home placement leads to renewed or discovered closeness of familial bonds” (Bowers, 1988, p. 361). Some of the individuals who participated in this study spoke about closely knit family bonds that encouraged them to provide assistance to their older parent both prior to, during, and after nursing home placement. This role was part of their being an “ideal caregiver” (Halpern, 1987). In addition to this, research has shown that after formal caregiving is organized, adult children are better able to meet the emotional demands made by their older parent(s) (Smith-Falde & Bengtson, 1979). This was part of the heartfelt caregiving that several research participants spoke about when reflecting on the good that happened after their older parent had moved into a nursing home.

For other individuals who participated in this study, caring for an older parent prior to, during, and post nursing home placement has been an extremely difficult experience that has contributed to intense family conflict. They describe situations where their sibling(s) have
simply refused to help care for their older parent. Absent caregiving sibling(s) have been overly critical of the primary sibling caregiver chastising them for the type of caregiving that they have provided. When communicating with one another, siblings in these families have resorted to confrontational communication. Typically, linked with confrontational communication are statements that are based on “…criticism, demands, hostile jokes and questions, denial of responsibility, “mind-reading,” and so forth” (Sillars & Wilmot, 1994, p. 174).

Research has shown that for some adult children who refuse to help with caring for an older parent, caregiving is perceived to be too burdensome (Byrne et al. (2009). Other research points to adult child reluctance to assume caregiving responsibility (Globerman, 1995), adult sibling dissociation from older families (Matthews & Rosner, 1988), and adult children not seeing themselves as the appropriate individuals who should be responsible for caregiving (Merrill, 1997) as being probable causes that contribute to family conflict. Directly put, “…at the root of many family conflicts are incompatible goals…” between individual family members (Roloff & Chiles, 2011, p. 687).

In chapter two, I also discussed in detail the different aspects linked to caregiving for an older family member. Factors such as adult child ambivalence and/or geographical distance away from the older family member, family history, sibling birth order, and sibling gender – overwhelmingly, the majority of caregivers in central and southwestern New Brunswick continue to be women – influence the type of caregiving that older family members will receive. Caregiving itself is said to be very challenging and may contribute to caregiver strain and physical and/or psychological stress. Family conflict may erupt when one or more of these identified factors arises. When this occurs, it is important that the conflict is concretely identified so that specific steps can then be taken to assist in addressing the conflict.
From a theoretical perspective, I argued that family conflict itself can be understood with the application of five different theories. These theories are: interpersonal conflict theory, developmental theory, life span/life course theory, inequity theory, multi-level theory. Of these theories, I argued that inequity theory is the strongest.

**Equity/ Inequity Theory**

Equity/Inequity theory states that family conflict – in this study, sibling conflict – will occur when disputing family members do not believe that they are being treated equally or that their interests – based on different family levels - are being heard. In a research study conducted with children, it was shown that “…when conflict of interest was high and sibling relationships were negative, children’s use of contentious strategies resulted in their failing to resolve their differences …” (Ram & Ross, 2001, p. 1718). I argue that the same holds true for adult sibling relationships.

Following a similar argument as Ram & Ross (2001), Adams & Laursen (2007) argue that negativity contributes to feelings of “…apprehension that are antithetical to supportive relationships” (p. 454). As evident in the data presented in Chapters Four through Seven, when individual adult siblings cannot agree on the type of caregiving that should be provided for their older parent(s), they experience disappointment, disbelief, frustration, anger, and even sadness. This may then contribute to a complete break-down and eventual cessation of the sibling-sibling relationship. It is important for one to remember that shared caregiving by family members may not be something that has been agreed upon. Given et al. (2012) argue that “family members are seldom prepared to be caregivers, and there is often little time for preplanning (p. 58). In their interviews, the majority of research participants stated that their families had not spoken about what kind of caregiving would take place for their older parent. There had been no family-based
advanced healthcare planning. I contend that because of this, the risk that some family members will perceive family caregiving as inequitable will be greater than it otherwise might have been.

In chapter three, I introduced qualitative research methodology as a critical tool when researching family conflict, aging families, and nursing home placement. In this chapter, I focused on the three research questions that guided my study. The three research questions are:

1) How does conflict occur within families who have placed a family member in a nursing home?

2) Utilizing phenomenology, how can we better understand conflict in families who have placed a family member in a nursing home?

3) What kind of conflict resolution practices and social policies can be put into place to assist families should they experience conflict as a result of nursing home placement?

I argued that the best qualitative approach when answering these questions is modified transcendental phenomenology. Transcendental phenomenology is beneficial as its focus is learning more about the lived experience of research participants. Following a modified transcendental phenomenological research method (Cooper, 2010, Lindseth & Norberg, 2004, Pollio et al., 1997) I have shared the lived experiences of women who have been in conflict with their siblings prior to, during, and after placing an older parent in a nursing home.

Transcendental Phenomenology

The chief advantage associated with qualitative transcendental phenomenology is that it “describes the common meaning for several individuals of their lived experiences of a concept or phenomenon” (Creswell, 2013, p. 76). Transcendental phenomenology is a particularly advantageous research method as it provides strong textural and structural descriptions (Moustakas, 1994) of the lived experiences of research participants. Transcendental
phenomenology thus allows me to answer the second question in this study. A phenomenological understanding of conflict in older families led me to break-down family conflict, as it occurs in connection with family caregiving, prior to, during, and after nursing home placement of an older parent. This type of conflict can be understood as something that has been influenced by family history, sibling conflict, and poor sibling communication. All of the research participants who I interviewed spoke about these three areas in greater or lesser detail. While it is not possible to go back and change family history, one can address and change sibling relationships for the better by opting to use quality family communication. In her discussion about quality communication, Patterson (1988) states that “quality communication is of particular importance to stress management in families because it enables the group to coordinate their efforts …” (p. 216). By coordinating family efforts, interpersonal sibling conflict can be effectively reduced.

Utilizing semi-structured interviewing, I discussed the various ways of recruiting research participants. Next, I discussed the inter-connected qualitative steps in the study. They are: adhering to ethics protocol, recruiting research participants, interviewing, transcribing audio recordings, coding transcriptions, and data analysis. I also showed how qualitative research can be said to be rigorous by creating an audit trail. Ultimately, however, as Patton (1999) argues,

A qualitative analyst returns to the data over and over again to see if the constructs categories, explanations, and interpretations make sense, if they really reflect the nature of the phenomena. Creativity, intellectual rigor, perseverance, insight – these are the intangibles that go beyond the routine application of scientific procedures. (p. 1205)
Communication

In their discussion about family conflict and end of life caregiving decision-making, Kramer at al. (2006) point to three key communication strategies as ways of addressing and preventing what they refer to as “coming out of the woodwork” family conflict (p. 799). I believe that these three communication strategies can also effectively serve as a communication beginning point in families who are faced with nursing home placement. The three strategies are: communicating in such a way that nonjudgmental and supportive caregiving statements are shared, family members meeting to discuss the possibility of nursing home placement well before this actually occurs, and providing family members with nursing home literature so that they are able to reflect on and work with this type of long-term care (p. 799). Essentially, what Kramer et al., are arguing in support of is increased transparency in caregiving decision-making facilitated through increased positive family communication.

As evident in this study’s research data, family conflicts can be extremely volatile. Increased family discussion long before nursing home placement becomes a reality, can help address the interpersonal strains that contribute to family conflict. When nursing home placement does occur - based on effective transparent communication – family members and nursing home staff should then work to establish a solid rapport with each other as this can only benefit nursing home administrators, staff, residents, and family members in the long run.
The Possibility of Family Mediation

In some families where conflict between family members has reached an impasse, it may well be very beneficial for the family as a whole to agree to participate in conflict coaching (Jones & Brinkert, 2008), facilitation (Schwarz, 1994) or family mediation. Based on Berkovitch’s (1999) definition for mediation, Donohue (2006) defines mediation as a … decision making process, activated when parties cannot solve their own problems, that involves an acceptable, neutral third party who assists disputants with their decision making. (p. 212)

In her discussion about family mediation, mediator, Alison Taylor (2002), states that “family mediation is a messy business, dealing with self-concept, face-saving, high emotions, crisis, past background, and identity issues for all participants” (p. 60). Reflecting once again on the research data that I presented and discussed in Chapters Four to Seven, it is more than evident that families can become very volatile units when faced with caregiving and nursing home placement. In spite of their volatility, it may well be extremely beneficial – provided that family members are not coerced – for families who are experiencing conflict to engage in mediation.

The chief advantage of the mediation process in relation to family conflict is that “mediators help overcome the lack of common assumptions or shared interaction rules by managing the process of discussion” (Sillars & Wilmot, 1993, p. 187). Interpersonal communication moves away from casting blame and hurling hateful comments to communicating so that the best interests of the older parent are placed in focus. In his discussion on the framework that mediators should follow, Christopher Moore (1996) introduces twelve stages. In relation to family conflict and caregiving, what is critically important is the emphasis that he places on mediating strong emotions. Moore states that “for a mediator to assist parties in reaching an agreeable solution, he
or she must work at least to minimize or neutralize the effects of negative emotions and, if possible, to create positive feelings between disputants” (p. 162). It would seem almost impossible that interpersonal family conflict can be overcome. However, by untangling counterproductive angry family communication, addressing hurtful emotions, listening to individual concerns, mediation may be the only way that the best interests of the older parent can actually be safeguarded.

Limitations of the Study

This study is limited in four ways. First, I was unable to find male research participants. In spite of the fact that I publicized the call for research participants in many public areas in central and northwestern New Brunswick, no men agreed to be interviewed. Research indicates that some men do choose to be family caregivers (Kramer, 2000; Gaugler et al., 1999; Harris-Braudy, 1998), this is in spite the fact that caregiving continues to absolutely be gendered. Overwhelmingly caregiving is gender biased towards women, thus excluding men. This does not mean that men are not caregivers, but, what it does mean is that the voices of male caregivers are not being heard.

Second, New Brunswick is an officially bilingual province, with English and French as the two primary languages. For this research, I was only able to interview English-speaking women. This does not then allow for adequate representation of the language diversity of the province, in particular of Acadian, some of whom only speak French, representation in this study.

Third, New Brunswick while not a racially diverse province - the majority of residents are Caucasian – there is a large population of First Nations peoples in the province, and nursing homes designed specifically to look after First Nations peoples. My study would have been
enriched and more representative of the province had I been able to interview First Nation people.

Fourth, New Brunswick is not a culturally diverse province. The majority of residents are of Acadian (French), Irish, Scottish, and British ancestry. The little Research that has been done in this area (Willis, 2012; Yarry et al., 2007; Aranda & Knight, 1997) indicates that culture does impact on individual involvement with and type of caregiving performed.

Recommendations

Identifying and understanding conflict in families as a result of nursing home placement can provide the impetus for developing best practices and up-to-date public policy - a necessary step forward in an era where baby boomers are aging and more and more families will be faced with the reality of placing older relatives in a nursing home. When answering the third question asked in this study, one significant way that family conflict can be addressed is by placing greater importance on the need for increased interpersonal communication within families as they age. “Communication skill is frequently identified as a critical family-system resource” (Patterson, 1988, p. 216). In her discussion on the importance of communication in families, Tannen (2001) states that

All family members struggle with the conflicting needs to be safe in the family’s protection and free from the family’s control – to get a center seat in the family pew and to avoid being left out. And these struggles are reflected in our conversations and in our conflicts. (p. 55)

Like Tannen, Caughlin et al., (2011) stipulate that

…few would argue with the premise that communication is the means by which family relationships are established and maintained, attachment and intimacy
are created, children are socialized, gender roles and expectations are formed, decisions are made, problems and conflicts are resolved, social support is provided, and the physical and mental well-being of others are affected. (p. 683)

Utilizing communication, there are two ways that family inclusion and conflict management can be achieved. First, by enhancing communication between older families and nursing home administrators and staff, family conflict can potentially be avoided all together. Second, by facilitating increased communication regarding long-term caregiving options and practices for an older parent between siblings - prior to, during, and after nursing home placement - can make the process much more transparent than in many circumstances it has been. This may require, for example, the assistance of a professional family mediator who can both facilitate and empower (Bush & Folger, 2005) family members to set aside their differences and work in ways so that long-term caregiving of the aged is as much as possible a positive experience. In addition to mediation, alternatively families might opt to engage in conflict coaching (Jones & Brinkert, 2008) or facilitation (Schwarz, 1994) as ways of comprehensively addressing family conflict.

In a recent research study on families and communication, families who based caregiving decision-making on high communication as opposed to low communication experienced less conflict (Lyles-Wittenberg et al., 2012). Lyles-Wittenberg et al., define high communication as “…free, spontaneous interaction between family members…” (p. 263). They argue that for low communication families, “…family conversation patterns do not engage in discussions about illness…” (p. 263). They state that these families “are more likely to experience family conflict…” (p. 263). The data in this study strongly supports the theory introduced by Lyles-
Wittenberg et al.’s on the link between specific communication patterns and the degree of family conflict.

Another recommendation where more should be undertaken is in the area of alternate formal long-term care models. In New Brunswick, alternate formal long-term care continues to be based on the medical model. As I have argued, some individuals state that the medical nursing home model is now outdated. Client-driven inclusive models such as the Eden Alternative, Green House, and Pioneer Network may be more appealing to baby boomers who require formal long-term care. This interest will put pressure on government to enact change. With additional research, governmental policy makers will have the necessary information on which to base innovative public policy in the area of long-term formal caregiving.

Future Research

Private versus Public

Borrowing from Bourdieu, one critical way that one can interpret group life and conduct is to examine the private versus public aspects of family caregiving. In his discussion about social context, Bourdieu (1977) makes the argument that

…we can understand social context in terms of the structured social relations between individuals, groups, and social institutions. Accordingly, social structure is embedded in everyday events that take place in social spaces. Social spaces in western culture are thought of as private or public domains of social action

(Sutherland and Feltey, 2010, p. 16)

How does placing a family member in a nursing home impact on private (Caughlin et al., 2013) and public (Cathy, 1972) social space in connection with formal caregiving? Why does this shift from private to public contribute to family conflict in some families? How can this conflict be
best addressed within families, in nursing homes, and government long-term caregiving policy development?

A family’s decision to move an older family member to a nursing home is influenced by the gender of the caregiver. As I have indicated, one of the limitations of my study was that no men agreed to participate. Future research in the area of family conflict, caregiving, and nursing home placement needs to include male caregivers. In their research, Lee et al. (2013) argue that “…individuals will vary in how they perceive their roles” (p. 1253). Do some men perceive their roles then differently than women when it comes to caregiving and nursing home placement? If so, why is this the case?

Additionally, future research must include families of different races and ethnic groups. Only when we hear about the lived experiences of families who are from diverse races and ethnicities will we begin to have more research that then influences public policy which is accessible to everyone.

The availability of affordable in-home versus affordable nursing home care is also an area that deserves more research? What sort of financial burdens are families faced with when an older family member moves to a nursing home? (Connidis, 2010; Coghlan, 2009; Matthews, 2002). Is government doing enough to help older families who require financial assistance?

Finally, future research should be undertaken to explore whether or not government is sufficiently aware of the innovative contemporary models for long-term care? Is government working to put alternate long-term care models in place?

My research is useful as it can better equip families, nursing homes, and government when addressing systemic issues that exacerbate and turn nursing home placement into a very complex issue. Revising and updating specific policies so that older families who may be faced
with nursing home placement are treated fairly and in a dignified way. Nursing home placement is a critical part of formal caregiving (Connidis, 2010; Matthews, 2002; Gubrium, 1993) and “as we look ahead, growing numbers of old people…are more likely to use formal care in institutional settings…” (Connidis, 2010, p.277). Moving a family member to a nursing home can be a very difficult experience fraught with second guessing and fear of the unknown (Dellasega et al., 1995). Until the time comes to for families to consider nursing home placement, they do not think about it – making immediate nursing home placement very stressful.

In her discussion about nursing homes, Gwyther (1998) argues family members are faced with balancing visits to the nursing home along with other family obligations, work, and other life concerns. Boelk & Kramer (2012) state that “few families are perfectly cohesive, and under stress of illness, hidden tensions may easily erupt” (p. 656). Nursing home placement can be one of the stressful times when tensions in older families – manifested as conflict – occur.

In an attempt to better understand how this type of family conflict does occur,

In addition to gender, future research should look at the importance of culture and race relating to conflict in family caregiving and nursing home placement. Race has been shown to be an influential factor in connection with commitment to help provide caregiving with more African-American’s and Latina’s participating in caring for older family members (Kolb, 2000; Wallsten, 2000; Stommel et al., 1998; Burton et al., 1995) than Caucasians. I have argued that these two areas do impact on the type of caregiving that families provide with family conflict de-escalating or being virtually non-existent in some cultures and races. How do culturally and racially distinct families who live in the United States, Canada as well as in other Western and
non-Western countries engage with caregiving and how in turn does this impact on family conflict?

For example, my own future research will look at the conflict experiences of aging caregiving families and nursing home placement in French-speaking Acadian families who live in New Brunswick and a comparison of the lived experiences of these families with English-speaking non-Acadian families will serve to expand our knowledge of aging families, caregiving, formal caregiving, and governmental policy and services for the aged in society.

The research area of family conflict, caregiving, and nursing home placement is complex and because of this much that still needs to be done so that formal long-term care is dignified, affordable, and empowering. Aging is an unavoidable process. Proactive steps that enrich the aging process are therefore something that are very much needed to facilitate quality of life.
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INTerviewer Looking for Participants

I am a PhD candidate interested in interviewing families about their experiences as a result of placing a family member in a nursing home and the conflict(s) that happened.

If you are interested in an hour long confidential interview, please contact me either by email at:

stephenj@stu.ca

or by telephone:

(506) 454-7479

Your confidentiality and privacy are completely assured.

This study has been reviewed by, and received ethics approval through the Research Ethics/Institutional Review Boards at St. Thomas University and Nova Southeastern University

(STU REB #2012-18, NSU IRB #0926121)
(Appendix B)

Interview Guide

1. Tell me about yourself? 2. Tell me about your family?

3. I am interested in how family members experience the process of placing a family member in a nursing home, and the conflict that can result from this process. I just want you to tell me about your experience. You can start where you want, and end where you want, I just want to hear your story.

PROBES

Extended hospital stay?

Conflicts in the hospital?

Family doctor/nurse role?

Placement?

Early days at nursing home?

Afterwords/More Recently?

Family history?

Parental-Child Relationship?

Sibling Relationship?

Financial challenges?

Emotional challenges?

Future challenges?
People’s Experiences of Placing a
Family Member in Nursing Home
Seeking Research Participants

My name is Stephen Pidwysocky. I am a faculty member at St. Thomas University in Fredericton, NB, and a PhD student studying conflict analysis and resolution at Nova Southeastern University, located in Ft. Lauderdale, Florida.

For my PhD degree research, I am examining conflict in families resulting from placing a family member in a nursing home. My interest in this area arose from the three year process my family experienced when we were faced with the reality of placing my mother-in-law in a nursing home here in New Brunswick. My family experienced much conflict and realized that very few services are available to help families as they move through what is often a difficult and painful process. I am hoping that my research will help change this.

I realized that my family could not have been the only one to experience conflict in this situation.

Therefore, I see my research as an opportunity for other people to share their wide ranging experiences with conflict as a result of nursing home placement. Through private interviews people can share their stories in a safe, comfortable environment. The interviews will be kept in strictest confidence and your identity will be closely protected.

If you are interested in participating in my research and/or have any questions about my research, please feel free to contact me at: 454-7479 or stephenj@stu.ca

This study has been reviewed by, and received ethics approval through the Research Ethics/Institutional Review Boards at St. Thomas University and Nova Southeastern University.

(STU REB #2012-18, NSU IRB #0926121)
(Appendix D)

First Cycle Codes

The key themes/areas that I identified during first cycle coding were: family size, sibling genders, sibling order, memories of siblings, hurtful and non-hurtful sibling communication, sibling losing voice, no communication, communicating with anger, multigenerational, sibling ambivalence, adult child caregiving dominance, parental selection of adult child caregiver, sibling pressures, sibling geographical distance, informal caregiving, formal caregiving, financial strain, and future caregiving.

Several sub-themes were also noted. They were: losing control, being feeling acknowledged, resentment, sibling selfishness, sibling self-protection strategies, setting boundaries, being “dumped on”, talking over one another, no regrets and no guilt, easy target, pretending, judgment, just move them into a nursing home, and family love.

Because the sub-themes, like the first cycle and second cycle codes were all interconnected to the larger area of caregiving and family conflict prior to, during, and after nursing home placement, I was able to include them when second cycle coding.
The Province of New Brunswick (in French – Nouveau-Brunswick) is located on the east coast of Canada. It is Canada’s only officially bilingual province with English and French being the most popular languages spoken. It is one of three provinces – New Brunswick, Nova Scotia, and Prince Edward Island – that make up the Maritime region of Canada. Atlantic Canada itself, consists of these three provinces along with the Province of NewFoundland a large island that sits in the North Atlantic Ocean. New Brunswick is largely a rural province and is heavily forested. It is bordered on the west by the Province of Québec, on the east by the Province of Nova Scotia, on the north by the Gulf of St. Lawrence and the Northumberland Strait, and on the south by Passamaquoddy Bay, the Bay of Fundy, and the State of Maine. Historically, New Brunswick’s economy was based on fishing and ship building. Today, fishing and forestry are the basis of much employment. The earliest settlers in the region were the Mi’kmaq, Maliseet, and Passamaquoddy Indigenous/First Nation peoples. After this, the Europeans, namely the Scottish, the Irish, and the Acadians established settlements in the region. The largest city in New Brunswick is Saint John followed by the cities of: Moncton, Fredericton, and Edmundston. There are six universities in New Brunswick. The capital city of New Brunswick, Fredericton, established in 1783, is located in the central region of the province on the St. John River which flows from northeastern Maine to the Bay of Fundy and then into the North Atlantic Ocean. The Province of New Brunswick was one of the first provinces to join the Canadian Confederation on July 1st, 1867.