The Pennsylvania State University

The Graduate School

College of Health and Human Development

PERSPECTIVES ON ETHICAL CARE FOR OLDER ADULTS:
EXPLORING PERSONAL CARE AND FAMILY SUPPORT

A Dissertation in
Human Development and Family Studies

by
Allison M. Reamy

© 2013 Allison M. Reamy

Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Philosophy

December 2013
The dissertation of Allison M. Reamy was reviewed and approved* by the following:

Steven H. Zarit, Chair
Professor of Human Development and Family Studies
Head of the Department of Human Development and Family Studies
Dissertation Advisor
Chair of Committee

Martin J. Sliwinski
Professor of Human Development and Family Studies

Lynn M. Martire
Associate Professor of Human Development and Family Studies

Dennis G. Shea
Professor of Health Policy and Administration
Associate Dean for Undergraduate Studies and Outreach

*Signatures are on file in the Graduate School.
ABSTRACT

Older adults increasingly rely on support from others to attain their goals in daily life. Adult children often offer support and become surrogate decision makers. However, children and their aging parents do not always see eye-to-eye on daily care goals. When goals clash, an older adult may be perceived as insisting, resisting, or persisting in their ways or opinions, or acting in a way commonly attributed to stubbornness. Such situations likely affect relationship and individual outcomes of families; yet, they are not well understood.

This dissertation compiles three studies that examine elders’ behaviors commonly attributed to stubbornness. Study 1 uses semi-structured interviews with aging parents and their adult daughter caregivers (N = 10 dyads) to develop a broad understanding of how elders influence their care (including through stubbornness). Study 2 (N = 88 dyads) and Study 3 (N = 221 adult children) use survey data to examine the association between elders’ persistent behaviors and individual and relationship-based characteristics, as well as the effect of children’s responses to such behaviors.

Study 1 demonstrates complex patterns of responses within families when there is conflict in care goals. Parents most commonly let go of their requests, while daughters reason with the ir parent and make decisions when they perceive safety or health-related needs. However, parents also display insisting and persisting behaviors. Study 2 confirms that adult children perceive their parents as acting in ways commonly attributed to stubbornness fairly often, and aging parents also self-report acting in this way. However, perceptions are linked to differential individual and relationship-based factors, and there are systematic differences in perceived parent stubbornness by adult children and their aging parents. Last, Study 3 shows that it is not just the perception of behavior that matters, but how adult children respond to their parents’ persistent behaviors that affect children’s depression, relationship quality, and support provided.

Overall, this dissertation demonstrates that micro-level processes of responses to goal conflict within families affect care and support. Intervention work that addresses positive ways of responding to one another and encourages shared goal setting could prove useful in supporting elders into their latest years.
TABLE OF CONTENTS

List of Tables ......................................................................................................................... vi
List of Figures ........................................................................................................................... vii
Acknowledgements .................................................................................................................... viii

Chapter 1. Introduction ............................................................................................................. 01
  1.1 Overview of the Problem ................................................................................................. 01
  1.2 Overview of Research .................................................................................................. 02

Chapter 2. Literature Review .................................................................................................... 06
  2.1 Theoretical conceptualization ...................................................................................... 08
  2.2 Theories in the context of later life ............................................................................... 14
  2.3 Implications for providing care and support in families ............................................... 16
  2.4 Conclusions ................................................................................................................. 24

Chapter 3. Study 1—Elders’ Influence in Family Care: Do Daughters Rationalize Restriction of Care Influence for Aging Parents? 26
  3.1 Abstract ......................................................................................................................... 26
  3.2 Background & Significance .......................................................................................... 27
  3.3 Research Hypotheses ................................................................................................... 32
  3.4 Method .......................................................................................................................... 32
  3.5 Results .......................................................................................................................... 37
  3.6 Discussion ..................................................................................................................... 45

Chapter 4. Study 2—“He is so stubborn!”—Adult Children’s and Aging Parents’ Perceptions of Elders’ Persistence, Insistence, and Resistance 60
  4.1 Abstract ......................................................................................................................... 60
  4.2 Background & Significance .......................................................................................... 61
  4.3. Research Hypotheses ................................................................................................. 67
  4.4 Method .......................................................................................................................... 69
  4.5 Results .......................................................................................................................... 78
  4.6 Discussion ..................................................................................................................... 83

Chapter 5. Study 3—The Consequences of Adult Children’s Responses to Parent “Stubbornness” 103
  5.1 Abstract ......................................................................................................................... 103
  5.2 Background & Significance .......................................................................................... 104
  5.3 Research Hypotheses ................................................................................................. 108
  5.4 Method .......................................................................................................................... 109
  5.5 Results .......................................................................................................................... 118
  5.6 Discussion ..................................................................................................................... 122

Chapter 6. Conclusion and Overall Discussion of Dissertation ........................................... 135

References ............................................................................................................................... 143

Appendix A: Study 1 Participant Sign up .............................................................................. 151
Appendix B: Study 1 Adult Daughter Screener ........................................................................ 152
Appendix C: Study 1 Parent Screener .................................................................................... 155
Appendix D: Study 1 Adult Daughter Interview Guide ................................................................. 158
Appendix E: Study 1 Adult Daughter Demographic Questionnaire .............................................. 160
Appendix F: Study 1 Parent Interview Guide ................................................................. 162
Appendix G: Study 1 Parent Demographic Questionnaire .......................................................... 164
Appendix H: Study 2 Adult Child Target Parents’ Stubbornness Questionnaire ............................. 165
Appendix I: Study 2 Parent Stubbornness Questionnaire ............................................................ 167
LIST OF TABLES

Chapter 3. Study 1—Elders’ Influence in Family Care: Do Daughters Rationalize Restriction of Care Influence for Aging Parents?
Table 3.1 Sample descriptive statistics ................................................. 52
Table 3.2 Response strategies employed by adult daughters and aging parents when experiencing goal conflict in their day-to-day relationship ................................................. 53
Table 3.3 Described situations of goal conflict ........................................... 55
Table 3.4 Response strategies employed by adult daughters and aging parents when resolving a conflict or tension in their day-to-day relationship ................................................. 57

Chapter 4. Study 2—“He is so stubborn!”—Adult Children’s and Aging Parents’ Perceptions of Elders’ Persistence, Insistence, and Resistance
Table 4.1 Hypothesized regression relationships and actual relationships of proposed variables with perceptions of parents’ behaviors attributed to stubbornness by adult children, aging parents, and their discrepancy in perspectives ................................................. 93
Table 4.2 Variables examined in relation to parent and adult child reports of parent stubbornness ................................................. 94
Table 4.3 Correlations of individual and relationship-based characteristics with middle-aged adults’ reports and parents’ self-reports of parents’ stubbornness ................................................. 95
Table 4.4 Demographic, individual, and relationship-based characteristics entered into analyses ................................................. 96
Table 4.5 Descriptives of parent stubbornness items rated by middle-aged adult children and self-rated by their parents ................................................. 97
Table 4.6 Effect of individual and relationship-based characteristics on child-reported parent stubbornness ................................................. 98
Table 4.7 Effect of individual and relationship-based characteristics on parent self-reported stubbornness ................................................. 99
Table 4.8 The association of individual and relationship-based characteristics with discrepancy in reports of parents’ stubbornness ................................................. 100

Chapter 5. Study 3—The Consequences of Adult Children’s Responses to Parents “Stubbornness”
Table 5.1 Middle-aged adult children’s responses to parents’ behaviors attributed to stubbornness ................................................. 130
Table 5.2 The effect of adult child responses to parent behaviors attributed to stubbornness on adult child reports of depressive symptoms ................................................. 131
Table 5.3 The effect of adult child responses to parent behaviors attributed to stubbornness on adult child reports of relationship quality, support provided, and caregiving support provided ................................................. 132
Table 5.4 The pattern of effects of adult child responses to parent behaviors attributed to stubbornness on adult child reports of depressive symptoms, relationship quality, support provided, and caregiving support ................................................. 133
# LIST OF FIGURES

**Chapter 3. Study 1—Elders’ Influence in Family Care: Do Daughters Rationalize Restriction of Care Influence for Aging Parents?**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Pattern of response to goal conflict in care</td>
<td>58</td>
</tr>
<tr>
<td>3.2</td>
<td>Example patterns of responses to goal conflict in care</td>
<td>59</td>
</tr>
</tbody>
</table>

**Chapter 4. Study 2—“He is so stubborn!”—Adult Children’s and Aging Parents’ Perceptions of Elders’ Persistence, Insistence, and Resistance**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Hypothesized process of appraisal of parent’s behavior by child as “stubbornness”</td>
<td>101</td>
</tr>
<tr>
<td>4.2</td>
<td>Hypothesized association of perceived parent behaviors attributed to stubbornness with other variables</td>
<td>102</td>
</tr>
</tbody>
</table>

**Chapter 5. Study 3—The Consequences of Adult Children’s Responses to Parent “Stubbornness”**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Hypothesized consequences of child response patterns to parent’s behaviors attributed to stubbornness</td>
<td>134</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The pages that follow are a collection of four years worth of work and a product of a lifetime of built up curiosity that I could not have pulled together without the support and encouragement of many. Thank you to my participants, my funders, my mentors, my colleagues, my family, my friends, and my partner. Without each of you I would not be where I am today.

First and foremost, I am indebted to all the participants that provided data for my studies. To the older adults and their adult daughters who let me interview them and shared with me their experiences, I would like to say thank you. Their openness and willingness to help me out, despite the life challenges they were experiencing, was remarkable. Additionally, I could not have completed this work without the time and energy the participants of the Family Exchanges Project gave me.

Second, I would like to thank Donald Ford and Lorraine and Albert Kligman for the generous financial support they offered me during my doctoral education. Their gifts gave me the freedom and the ability to collect my own data for this dissertation, a challenge I am thankful to have had. The experience kept me grounded and connected to the real-world experiences of the individuals whom I aim to study and strive to serve through my work. A special thanks to Donald Ford for encouraging my curiosity in understanding the complex patterns of interactions between families and their older loved ones during my time at Penn State.

Third, I would like to thank Steven Zarit, my primary advisor and mentor during this endeavor. He has taught me about research, older adults, and their families these past four years and has helped me to develop into a professional in the world of gerontology. Every accomplishment I have moving forward will in part be of some credit to him, as he believed in me, encouraged me, and always was there to help me hash out ideas. He has truly helped me to build my confidence in who I am as a research scientist. His support has been irreplaceable. Also, I would like to thank Karen Fingerman who supported my dissertation goals and allowed me to partner with her in data collection through the Family Exchanges Study (funded by the National Institutes of Health: R01 AG027769-05). Her support gave me the resources I needed to explore the ideas I was interested in. Also, I would be remiss if I did not thank my committee for their time and energy in reviewing this document and providing feedback throughout my doctoral training. Thank you to Dennis Shea, Martin Sliwinski, Lynn Martire, and Kathryn Hynes for their support and for always challenging me to challenge myself. And, I thank the many others who have provided me with invaluable support and mentorship, including but not limited to my labmates and cohort at Penn State, Carol Whitlatch, Lynn Feinberg, Jodi Mindell, and Jennifer Crissman Ishler.

Last but far from least, I would like to thank my family, friends, and life partner for all the patience, encouragement, motivation, and inspiration they have offered me these past four years. When asked where the idea for my dissertation came from, I never fail to share that it was in fact a conversation with my own mom that sparked my interest—how do you respond to “stubbornness” of older adults? While we were ourselves challenged these past four years with loss and disability amongst my grandparents, they are the reason I study what I study. It is in interacting with them that I have been challenged to understand how we can better support their needs while helping my family’s goals be met. Thank you to my parents for encouraging a love of my elders and thanks to my grandparents for loving me more than I could ever ask for. And, to my soon to be spouse, thank you for being you and for always being there for me.
Chapter 1. *Introduction*

1.1 Overview of the Problem

Autonomy and control are critical psychosocial needs for development (Deci & Ryan, 2000). Thus, medically and socially there has been an increased focus on delivering *person-centered care*, whereby the person and his or her values are the focus and center of care delivery (Edvardsson & Innes, 2010). However, in the context of older adulthood, the practice of providing fully person-centered care is often compromised by individuals’ loss of physical and social abilities and decreasing ability to assert primary control that is partnered with an increasing need for social support (P. Baltes, Freund, & Li, 2005; Heckhausen & Schulz, 1995; Nolan, Davies, Brown, Keady, & Nolan, 2004). Evidence suggests that for individuals living with dementia (Elliott, Gessert, & Peden-McAlpine, 2009), older adults in nursing homes (Persson & Wästerfors, 2008), and for elders in some families (Cicirelli, 2006), elders’ own views are often not taken into consideration. Rather, caregivers often take on a role with great power for negotiation and decision making in care for elders in an effort to do what is ‘best for them’ (Pyke, 1999; Wilkinson, 2001). The person-centered nature of care is then challenged by this pursuit of control by multiple individuals.

Most pointedly, a mismatch in relationship or care goals likely leads to tension and conflict. In such instances, caregivers may discount elders’ preferences with the use of a ‘folk logic’, or account of their behavior, justifying their behaviors that limit elders’ requests as appropriate given constrained circumstances (Persson & Wästerfors, 2008). Or, elders may attempt to accomplish a goal and meet some resistance; they may then subsequently attempt to re-assert their goals, views, or perspectives through actions or words to achieve their goals (Freund, 2006; Wrosch, Heckhausen, & Lachman, 2000). However, caregivers may react to this
behavior of persistence (i.e., resisting advice or insisting on acting in a specific manner, acting in a way commonly attributed to stubbornness) in a way that affects the quality of their relationship or either individual’s functioning. Additionally, interactions where there is conflict in care goals and an elder is thought to persist in his/her ways or opinions despite possible negative outcomes may influence the provision of truly person-centered care. Yet, research has not addressed these concerns directly.

Given the critical role family members, particularly adult children, play in supporting elders, it is essential to understand how elders’ influence their relationships and the care and support they receive from family members. Furthermore, it is vital to understand how adult children respond to elders’ behaviors in everyday relationships but also in situations of caregiving. For, at the heart of the issue of providing truly ethical care for elders, is a need to figure out how we can best support elders’ personal autonomy and control within the context of their relationships. Such a knowledge base carries important implications for how society can intervene and support aging individuals.

1.2 Overview of Research

This dissertation focuses on relationships of elders with their adult children and consists of three studies that explore issues of how elder’s influence the care or general support they receive from their children, with a focus on situations where elders are thought to persist, or resist in their ways and/or opinions, i.e., act in a way commonly attributed to stubbornness. The dissertation utilizes a mixed-methods research design to achieve a fuller understanding of the perception of elders’ influence and how adult children respond to elders’ behaviors (Sandelowski, 2003). Study 1 uses semi-structured interviews to capture both the process and the meaning associated with elders’ influence in care (Luborsky & Rubinstein, 1995; Maxwell,
1998), with a specific interest in elders’ behaviors to resist or insist on acting in a specific manner. Meanwhile, Study 2 and Study 3 utilize structured survey data collected within a larger sample of middle-aged adults and elders, to assess the prevalence of elders’ resistant behaviors, understand what characteristics are associated with such behaviors, and the impact of middle-aged adults’ differential responses to elders’ behaviors. Overall, what the qualitative data lacks in breadth it makes up for in depth, while what the quantitative data lacks in depth it makes up for with its breadth (Mason, 2006). Each type of data collected informs the holistic understanding of this multi-dimensional process in families. Ultimately, the combination of survey and semi-structured interview methods produces a more comprehensive empirical record on this scantily researched subject.

**Study 1.** Semi-structured interview questions explored caregivers’ use of ‘folk logic’ (e.g., accounts of behaviors with accepted cultural rules to justify actions; Buttny, 1993; Persson & Wästerfors, 2008) and perception of elders’ insisting, persisting, or resisting behaviors. The interviews were designed to capture how elders influence their care (including through persistence and resistance, i.e., stubbornness), how caretakers (adult daughters) respond to such influence, and how caretakers rationalize the way they provide care. The interviews were analyzed using the constant comparative method of grounded theory to answer the following:

1. How do adult daughters and their aging parents perceive parents’ influence in daily care?
2. How do adult daughter family caregivers respond to daily involvement/influence of their elder parent?
3. Are verbal ‘folk logics’ or accounts employed by adult daughter family caregivers to discount adherence to elders’ preferences, as found in nursing homes (Persson & Wästerfors, 2008)?
4. How do elders and adult daughter family caregivers perceive and respond to conflicts in goals in daily care? Do elders resist or insist on acting in a particular manner? If so, how do family caregivers respond to such behaviors?

Study 2 & Study 3. Survey based data collected as a component of a larger multi-generational follow-up telephone interview study were used in Study 2 and Study 3 to assess middle-aged adults’ and their aging parents’ self-perceptions of parents’ insisting, persisting, or resisting behaviors (i.e., behaviors commonly attributed to stubbornness). These studies examined the prevalence of elders’ persistent behaviors, and their association with individual and relationship-based characteristics and behavioral responses by adult children. Study 2 utilized descriptive analyses, regression, and multilevel modeling to address the following:

1. How often do adult children perceive their parents as insisting or choosing to do something in a particular way when it may not appear to be in an elders’ best interest (i.e., acting in a way commonly attributed to stubbornness)?
2. How often do aging parents’ self-perceive themselves as insisting or choosing to do something in a particular way despite possible consequences?
3. What individual and relationship-based factors are associated with perceptions of elders’ behaviors to insist or resist?
4. How do elders’ self-perceptions correspond to their adult children’s perceptions of such behaviors? If there is a discrepancy in perception between aging parents and their adult children, what individual or relationship characteristics are associated with the discrepancy?

Study 3 then further explored middle-aged adults behavioral responses to such perceived behaviors by their aging parents. Again, utilizing descriptive analyses, regression, and multilevel modeling, Study 3 sought to answer:

1. How do adult children respond to their parents’ behaviors to insist, resist, or persist in their ways or opinions (i.e., behaviors commonly attributed to stubbornness)?
2. How do adult children’s responses to their parents’ behaviors affect depressive symptoms, their parent-child relationship quality, or the amount of general or caregiving support they provide to their aging parent(s)?

Overall, the findings of this dissertation demonstrate that responses to goal conflict in families with adult children and aging parents are complex. The responses employed by aging parents differ from those by adult children. And, adult children and parents report parents acting in ways commonly attributed to stubbornness (i.e., insisting or persisting in their ways or opinions). When behavioral responses to goal conflict arise in relationships, parents and children perceive the occurrence of such behaviors differentially. This difference, as well as individual perceptions of parents’ behaviors, is related to a host of individual and relationship-based characteristics of the parent and the child. The results of this dissertation are critical in advancing our understanding of how and why parents may persist in their ways or opinions and how families navigate such relationship conflict. They open up a discussion of the effect of elders’ own behaviors and the perception of such by family members on the delivery of person-centered care. Findings call for new adaptive approaches to facilitating support for elders within families.
Chapter 2. Literature Review

While adult development and aging can be a time of growth and fulfillment, in the context of evolution, older adults have seemingly been short changed. There exists a gap in biological and cultural support, referred to as the incomplete architecture of human ontogeny (P. Baltes, 1997). As adults age they increasingly lose biological plasticity, and increasingly rely on cultural support, yet they experience a decreased efficacy of cultural resources (P. Baltes, 1997). The ratio of gains and losses in functioning in adulthood, or the perception of this ratio, becomes essential to aging successfully. Older individuals who can maximize gains and minimize losses function best. As a result, older adults must learn to allocate their physical, mental, social, and cultural resources more efficiently and evoke dependency or support from others in one domain in order to maintain some level of functioning and/or independence in another (P. Baltes, Freund, & Li, 2005). Such dependency is not necessarily a negative outcome and can be vital to human growth and well-being. However, when environments do not match competencies and existing needs, such a reliance on social support can also be detrimental (M. Baltes & Silverberg, 1993).

For example, Margaret Baltes (1995; 1996) posits that social learning in both nursing homes and the community produces dependency support scripts in older adulthood. The environment often overly pampers the older adult, eroding an elder’s sense of control and actual control over patterns of behavior. More specifically, dependent behaviors (i.e., pushing an individual in a wheelchair versus allowing the individual to walk) are followed more often by dependent supportive behaviors (i.e., attention and praise), while independent behaviors are often ignored by care staff in nursing homes and sometimes by family caregivers in the community (M. Baltes & Wahl, 1992). Such behavioral patterns act as reinforcements to the dependent behavior, with older adults learning that they receive a positive response by acting submissively. Disregard for an elder’s competence and providing unneeded assistance directly challenges an
individual’s sense of autonomy and control and ability to provide self-care (Baltes & Silverberg, 1993).

The loss of autonomy and control in care is particularly concerning, as losses in such psychosocial domains of developmental functioning are linked to a series of negative outcomes, including, but not limited to, physical health declines, lowered self-esteem, and even mortality (Langer, 1983). Environmental and social changes can perpetuate or augment such loss, causing an even further interdependence on others and increased negative affect (Lawton & Nahemow, 1973). Thus, despite an increased reliance on social support by elders, there appears to be a simultaneous need to sustain autonomous functioning.

Researchers have documented the often-compromising environmental and social contexts in nursing homes and formal care institutions that challenge the autonomy of older adults (i.e., Persson & Wästerfors, 2008), but less is known about the environments in which autonomy and control, or even more broadly, the values held by elders, are honored or diminished in the family context. A large number of family members are providing care and support to elders in the home (National Alliance for Caregiving & AARP, 2009), and research articulates the presence of tensions in families where elders’ own views are not taken into consideration (Cicirelli, 2006). Additionally researchers have documented the unique tensions between mothers and daughters in regard to perceptions of aging and negotiating care (Fingerman, 1996; McGraw & Walker, 2004). However, a full understanding of how elders exercise autonomy and control, or more broadly influence their relationships and the care and support they receive from family members, is still lacking. In particular, it is unclear how elders’ preferences are addressed when their goals are in direct conflict to the goals of those who offer them support. Given the integral role families play in offering the social support needed to help complete the ‘architecture of human
ontogeny’ for elders (P. Baltes, 1997), more research is needed to learn how to support families more fully in caring for their loved ones. To address these concerns, it is first essential to understand the processes involved in autonomy and control, how they operate in older adulthood, and the implications they carry for providing ‘ethical’ care and support to older adults in the context of families.

2.1 Theoretical conceptualization:

Autonomy and control are interrelated psychosocial constructs that have been studied for decades and are discussed utilizing a multitude of terms including, but not limited to, self-efficacy (asocial, contextual, personal control over environment), locus of control (feeling of possessing power/obligation to control events or conditions), or mastery (feelings of control over personally important conditions; Pearlin & Pioli, 2003). Beginning their development in early childhood (Erikson, 1982, as cited in Cavanaugh & Blanchard-Fields, 2011) and extending into older adulthood (Deci & Ryan, 2000; Langer, 1983), both autonomy and control are considered fundamental aspects of the life course that are essential for psychological and physical functioning. Autonomy is conceptualized as the ability “to self-organize experience and behavior and to have activity be concordant with one’s integrated sense of self” (Deci & Ryan, 2000, p. 231). Meanwhile, personal control is a view that “one’s performance in a situation depends on something that one personally does” (Cavanaugh & Blanchard-Fields, 2011, p. 304). Ultimately, the processes involved for both are similar and can be understood in adulthood, in particular, through a few key theoretical orientations: self-determination theory (Deci & Ryan, 2000), a lifespan theory of control (Heckhausen & Schulz, 1995; Wrosch, Heckhausen, &
Lachman, 2000), and/or theories of subjective control (Abeles, 2003; Brandtstädter, 1984; Pearlin, Nguyen, Schieman, & Milkie, 2007).

Self-determination theory proposes that there are three interrelated psychological needs that direct behavior or goal pursuits: relatedness, competence, and autonomy (Deci & Ryan, 2000). In this frame, these innate needs are conceptualized as necessary conditions for continued psychological growth, health, and well-being, whereby satisfaction of such needs translates to effective functioning and self-determination. A fully self-determined individual is someone who acts upon an internal desire and choice that is concordant with his or her values. Relying on such intrinsic motivation, or fully integrated external motivation, then results in higher levels of well-being and mental and physical functioning.

Of particular interest in this theory is the innate need for autonomy (Deci & Ryan, 2000). The theory maintains that autonomous behavior fully integrates external behaviors with one’s personal values and results in a confident, goal-directed pattern of action by the individual. For example, a person acting solely on an external control-orientation is responding to the directives of others or the circumstances (e.g., acting just to satisfy a tangible outcome). Yet, a fully autonomous individual, views the outcome of a scenario, interprets his own actions, behaviors, and consequences, and integrates his understanding of such experiences into his own values. The individual then responds or acts again on these values derived from personal experience and reflection. This aspect of autonomy, while working in concert with the other two innate needs of competence and relatedness, is unique in that it is necessary for authenticity in behavioral actions (Deci & Ryan, 2000).

If the development of a need, such as autonomy, is stunted, it can lead to defensive adaptations. For example, an individual may develop an extreme desire for control if
competence and autonomy have been neglected in development, which can lead to acting in an anti-social manner. In contrast, if autonomy is supported, goals can become internalized and behaviors can become self-regulated, which, in turn, is related to behavioral persistence, personal adjustment, positive coping, and improved mental and physical health (Deci & Ryan, 2000). Overall, the theory posits that while there are individual differences, the psychological needs of autonomy, competence, and relatedness are universal needs, and autonomy, in particular, is essential for self-organization and functioning across cultures, throughout the lifespan.

In a related vein, Heckhausen and Schulz (1995) take the understanding of self-directed action a step further than self-determination theory with their articulation of a lifespan theory of control. As with the conception of autonomy by Deci and Ryan (2000), whereby autonomy is the desire to self-organize experiences in tune with one’s sense of self, control for Heckhausen and Schulz is the perceived sense of self-direction of one’s actions. In their theory, Heckhausen and Schulz view the experience of control as a central process in human development from infancy to old age (Schulz, Wrosch, & Heckhausen, 2003), positing that humans seek to control their life outcomes and act to avoid loss of control to maintain their sense of self. However, Heckhausen and Schulz (1995) make a key distinction between primary control and secondary control. Primary control is considered individual “behavior directed at the external environment” to “change the world to fit the needs and desires of the individual” (Heckhausen & Schulz, 1995, p. 284). It is the individual’s effort to influence directly the external environment he or she resides in. Such primary efforts may be real or illusory, which can be functional or dysfunctional. A person may have real functional control over a situation, such that he or she alters the circumstances, or illusory functional control, whereby a person acts based on invalid beliefs but the circumstances still turn out okay. Or, a person may act with real control
in a dysfunctional way, such as over extending oneself to achieve a short-term goal. Or, lastly, the most harmful primary effort for control, a person may act on dysfunctional illusory attempts to maintain control, for example exhibiting superstitious behavior. These forms of primary control are adaptive or maladaptive in differential circumstances.

Meanwhile, secondary control “helps the individual to cope with failure and fosters primary control by channeling motivational resources toward selected action goals throughout the life course” (Heckhausen & Schulz, 1995, p. 284). So, while primary control is principally action based, secondary control is based on cognitive interpretations of situations. In particular, there are two inherent limits to human functioning that make this second form of control necessary: (1) the proneness of human behavior to failure, and (2) the need to select which goals to pursue. As a result, individuals utilize secondary control strategies, such as shifting expectation biases (i.e., what one expects to occur based on actions), altering goals (i.e., giving up unattainable goals), and/or refocusing attributions of causes to outcomes (i.e., to real causes, not pessimistic, self blaming attributions), to buffer against the negative effects of failure and to sensibly direct one’s actions. Individuals use such cognitive strategies to maintain or minimize losses in primary control without actually physically engaging the environment prior to decisions to act, during the action, or after the action has occurred. Ultimately, primary control takes precedence over secondary control, and individuals will act to assert primary control over their environment and circumstances; however, if primary control is inhibited individuals will try for secondary control. The two forms of control act in concert with one another for the individual to maintain self-direction of action. Thus, like autonomous motivation in self-determination theory, the desire for self-organization leads to use of these control strategies to maintain a congruent sense of self (Heckhausen & Schulz, 1995).
In addition to self-determination theory and the lifespan theory of control, theories of subjective control explicate that beyond primary control one’s sense of control can drive developmental outcomes. Several researchers have articulated how internal beliefs or characteristics of an individual’s experiences can affect a person’s sense of control, including but not limited to Abeles (2003), Brandtstädter (1984), and Pearlin et al. (2007). In a model of sense of control, Abeles (2003) suggests a person’s subjective interpretation of the antecedents and consequences of one’s behaviors shape one’s perceptions of control. Beliefs and expectations regarding one’s self and environment act in partnership with the actual features of one’s environment in a feedback loop. One’s experiences shape beliefs while beliefs will then shape one’s subsequent experiences, such that if one believes they have control this will influence how they act which then will influence their subsequent feelings of control. In this model, control beliefs are viewed as dynamic and ever changing and can be either global (i.e., a generalized belief of being able to control conditions in one’s life; Pearlin & Pioli, 2003) or domain-specific (i.e., having a sense of control over a particular role or function; Abeles, 2003). And, regardless of scope, there is an age related stability in sense of control, such that studies do not show a universal decline in sense of control despite increased sense of loss in old age (Abeles, 2003).

Brandtstädter (1984), in discussing an action perspective theoretical framework to understanding development, further supports such ideas, explicating that one’s actions and life outcomes depend upon a combination of expectations, values, and control beliefs related to functioning. One’s motivation and goals can alter how one perceives a situation or stimuli. Individuals are shown to attend to evidence in their environment or perceptual field that is personally relevant, is of a similar valence to their mood, or if they perceive having control over an outcome in a given situation (Brandtstädter, Voss, & Rothermund, 2004). Thus, control
beliefs are key to directing one’s actions and to one’s perceptions. Furthermore, development, and successful aging are directly related to one’s ability to foster and maintain control beliefs (Brandtstädter, 1984) and the ability to adjust goals in the face of losses and constraints (Brandtstädter, 1984).

Lastly, Pearlin and colleagues (2007) articulate the development of life-course mastery. Similar to one’s sense of control, mastery is conceptualized as one’s understanding of his or her ability to control the circumstances in his or her life that are personally relevant. In the life-course, it is the sense that a person has self-directed his life to where he is today. One’s sense of direction in the past helps to shape current feelings of mastery. The life-course itself, thus, mediates individuals’ past and current levels of mastery. While salient and persistent stressors can erode mastery, a sense of self-direction can lead to improved health and well-being. This expansion in theoretical understanding of control/mastery, in particular, implicates a role of one’s past experiences in shaping one’s psychosocial feelings of control (Pearlin et al., 2007).

Overall, these theoretical frameworks complement one another, presenting control and/or autonomy as multidimensional characteristics of human development that are essential to psychological and social functioning throughout the lifespan. The key component across these theories is the importance of self-direction in action-based outcomes of an individual either through direct action or interpretation of actions. The presence of self-direction allows for a sense of consistency in one’s beliefs and actions—an individual acts in a way that aligns with his or her sense of self. Without this component of self-directed ownership on behaviors, theory implicates that individuals’ adjustment and well-being may suffer throughout the lifespan.


2.2 Theories in the context of later life:

More specifically, in terms of the theoretical orientations of self-determination theory, the lifespan theory of control, and theories of subjective control, it can be seen that autonomy and control remain essential to development and functioning in adulthood, but there is a necessary shift in how autonomy and control operate for older adults.

Self-determination theory implies three ideas in regard to autonomy and aging: (1) lack of development of the innate psychological need of autonomy can thwart later functioning and development, (2) autonomy support can increase one’s feelings and experiences of autonomy, and (3) autonomy and perception of such is still needed later in life. If an individual fails to develop an autonomous self-determined sense of self earlier in life, whereby one builds the capability to act on intrinsic motivation or integrate and internalize extrinsic stimuli, one may not have this ability in adulthood. The individual’s growth, health, and well-being may have already suffered. Secondly, the theory hints at the positive effects extra autonomy support may have on allowing the development of autonomy and the learning of self-directed behaviors by the individual. With support, there is a likelihood that individuals can learn to act more autonomously. Third, autonomy is postulated by self-determination theory to be an innate psychological need for human development. As a result, autonomy is a need that exists throughout the lifespan. It remains a necessary component for healthy development, even in the face of age-related loss. Thus, one’s autonomy and sense thereof may be related to earlier development and/or shaped by subsequent support, but autonomy, from the stance of self-determination theory, is still necessary in adulthood.

Meanwhile, the lifespan theory of control proposed by Heckhausen and Schulz (1995) specifically addresses how control processes operate in adulthood in one key way. The theory
suggests that as individuals age they continue to embrace opportunities to directly control outcomes in their lives, but the dispersion of control efforts between primary and secondary strategies may shift. With decreased biological and cultural support in adulthood, there is a decline in power in the form of primary control that older adults can assert, which can be distressing, as evidence suggests that the need for internal control remains stable. As a result, individuals must increasingly depend on secondary control processes in order to maintain the positive effects of control on well-being (Heckhausen & Schulz, 1995). In examining the use of secondary strategies of older adults, as compared to younger adults, Wrosch and colleagues (2000) demonstrated that persistence in goal striving (primary control) was higher in older adulthood than younger adult age groups, but that it was not associated with well-being outcomes in the oldest age groups. Rather, persistence (a primary control effort) appeared to be adaptive in younger groups, but not in older groups. The use of positive reappraisals (a secondary control strategy) had a stronger impact on well-being in middle and older adults than in younger adults. Therefore, while primary control was more adaptive for younger adults, the assertion of secondary control was more adaptive in older adults.

Lastly, theories of subjective control can also be applied to older adulthood. The positive effects of perceived control are not context or age bounded; rather, beliefs, motivations, and goals simply affect actions, which, in turn, affect beliefs. As aforementioned, there is an age-related stability in need for sense of control. However, one’s past experiences will affect how one perceives his or her current sense of control, and similar to the implications of self-determination theory, negative early life experiences with control are likely to erode one’s current sense of control or mastery (Pearlin et al., 2007). Accumulating evidence supports such theories, by purporting the importance of perceived control and control beliefs in older adulthood
by decreasing mortality, increasing social participation, maintaining cognitive performance, maintaining health, and maintaining well-being (Infurna, Gerstorf, Ram, Scupp, & Wagner, 2010; Jopp & Schmitt, 2010). For example, Langer (1983) exemplified how the perception of helplessness, a perceived lack of control, can be just as disabling as actual loss of ability, even more so for older adults. In examining ability in four groups of residents residing in a nursing home, individuals that were in the “helped group” performed less well compared to those in the “encouraged only” or “no contact” groups. In this instance, the assumption of incompetence with provision of help initiates a removal of perceived control from disabled individuals and, thereby, reduces ability.

Overall, a decline in resources in adulthood may restrict elders’ ability to assert control in some situations; however, the internal need for autonomy, mastery, and control remains stable (Zarit & Braungart, 2007). Thus, according to the theories articulated, even in light of decline often experienced in older adulthood, autonomy and control remain essential psychological characteristics for continued development. Older adults need, and will use, autonomy and control to continue to function in a self-directed, authentic manner.

2.3 Implications for providing care and support in families:

In light of the incomplete architecture of human ontogeny (P. Baltes, 1997) it is clear that the outlined theoretical orientations carry important implications for the way in which we provide care and support to older adults. The theories purport the importance of maintaining elders’ experience of self-direction in action. This may mean there is a need to develop and administer appropriate assessment of an older individual’s values and preferences in care to ensure that both now and in the case that the individual can no longer voice his ideas his wishes
will be followed (Walaszek, 2009). It may also mean there is a need to push for greater person-centeredness in care to support autonomous decision making (Edvardsson & Innes, 2010). Or, it may mean allowing for greater support of autonomy over safety when making long-term care decisions (Kane, 1995). However, beyond these particular implications, such a discussion most pointedly implies the need for elders to use adaptive strategies to maintain their actual and perceived sense of self-direction in action as much as possible. And, such adaptive strategies must be situated in the context of elders’ increased reliance on cultural support.

The use of adaptive behavioral strategies may help elders maintain their actual and perceived sense of self-direction and also improve and increase feelings of autonomy, control, and positive affect in light of past developmental experiences (Lawton & Nahemow, 1973). One example of such an adaptive technique is the manipulation of the environment directly, adding technological support to get from one place to the next. A second strategy would be training an individual to change his own cognitive strategies through therapy (Lawton & Nahemow, 1973). Or third, a combination of active and passive adaptive strategies could be used with a technique such as selection, optimization, and compensation (S-O-C)—a process whereby loss is acknowledged but then accommodated for through one’s behavioral actions. An individual selects what he or she can do (i.e., limits resources such as time and energy to specific goals), optimizes where he or she can (i.e., allocates resources to achieve greater functioning for selected goals), and compensates when he or she is in need of assistance (i.e., uses alternative processes to maintain ability in a specific domain; Freund & P. Baltes, 1998). S-O-C enables an individual to assert oneself in a way that balances what one can do well and what one needs assistance with, to ultimately age successfully (e.g., be satisfied with age, lack of agitation,
absence of emotional and social loneliness; Freund & P. Baltes, 1998; Lang, Rohr, & Williger, 2011).

However, the training and practice of such adaptive strategies may not be enough and in most cases elders will need the addition of social support to allow for compensation to successfully function. Ultimately, autonomy is situated as a psychosocial need within the context of relatedness and competence (Deci & Ryan, 2000), lending credence to the need to facilitate or support self-direction in the context of one’s social relationships. Further, from a sociological perspective (Pescosolido, 1992), family systems theory perspective (White & Klein, 2008), and as dyadic coping theory posits (e.g., Berg & Upchurch, 2007), adults function within social systems and collaborate with others when making decisions and responding to stressors, such as illness or disability. An individual interacts with a significant other or supportive relative to develop joint coping responses (Berg & Upchurch, 2007; Bodenmann, 1995; Krause, 2003) and such supportive individuals become important resources for elders helping them to adapt to illness and respond to interventions (Martire, Lustig, Schulz, Miller, & Helgeson, 2004). Thus, Krause (2003) suggests that in addition to primary and secondary control, individuals can act with collaborative control. Couples may collaborate supportively (one helps the other), in a delegated fashion (one takes responsibility to reduce partner’s stress), negatively (hostile, ambivalent, or superficial coping), or jointly (equal participation; Lederman et al., 2010). But, ultimately, joint coping is seen as a desirable alternative for elders to use when faced with loss. As a result, in many instances, social support and personal control are integrally connected, suggesting that autonomy may be best supported for older adults, particularly those living in the community, not solely through person-centered care but dyadic-centered care (i.e., an elder and
another individual) or even family-centered care (i.e., an elder and his or her family; Feinberg, Nolan, Davies, Brown, Keady, & Nolan, 2004).

With this understanding of theory, an individual’s autonomy and independence must be balanced with families’ abilities and resources. Such a discussion parallels one in medical ethics, whereby principlism calls for the balance of autonomy with beneficence, non-maleficence, and justice (Hartnett & Greaney, 2008; Hughes & Baldwin, 2006). Autonomy in this regard is the ability for an individual to decide what he wants to have happen or to be done. Beneficence is that one should try to do good for the people one cares for. Non-maleficence says one should try to avoid doing people harm. And, lastly, justice denotes that people should be treated fairly and equally. An individual acting on the basis of principlism weighs the pros and cons of how a decision will impact these four principles, in hopes of maximizing the good and minimizing the harm. Autonomy can be honored then until it impinges upon the rights of others or causes undue harm. In the case of providing family care and support for elders, autonomy is balanced against the good, bad, and justice for self and others. For example, the precedence of autonomy is often weighed against the need for safety—can a frail elder opt to not use a walker as an autonomous choice, or is it causing undue harm? In light of principlism, control and autonomy expressed by the elder can be exercised, but within the parameters of co-existence with his or her family member(s). In this regard, provision of ‘balanced’ ethical care appears to come as a byproduct of encouraging adaptive responses by elders to their environments (Freund & Baltes, 1998; Lawton & Nahemow, 1973), maximizing what an elder can do for him or herself (i.e., respecting personhood; Nolan et al., 2004), and then relying on a family member for those things he or she needs most (i.e., valuing interdependence; Nolan et al., 2004)—creating a teamwork, or authentic partnership (Dupuis et al., 2011), approach to tackling the challenges the elder faces to balance...
the effect on all parties involved. Such a model of care may maximize the abilities of both members of the dyad, allowing each to contribute to the relationship and care. However, research has yet to fully articulate such a process and such a ‘balancing’ act is likely complex.

In particular, as theorized, an older adult needs autonomy, competence, and relatedness, but so does his or her family member. Both an elder and family member providing support or care are operating as individual complex systems trying to achieve their own motivational goals in daily life (Ford, 1994). Given the decrease of primary control efficacy in older adulthood (Heckhausen & Schulz, 1995), a continued persistence by older adults to maintain control (Freund, 2006), and this parallel need of their family members to maintain autonomy and control (Deci & Ryan, 2000), tensions in power are likely to develop. The shift in elders’ ability to practice certain forms of control likely allows family members who provide care or support to assert more overt power by taking control of the things an elder can no longer do. Meanwhile, the elder is forced to rely on hidden power, using secondary control techniques, to avoid conflict (Pyke, 1999). However, as one person’s goals develop, they may not match the goals of the other partner involved in providing care or support. In such cases a family member may hope to offer support in accomplishing a task (i.e., take the elder to the store), however, the elder may not share this same goal and prefer to accomplish this task in another way (i.e., walking the three blocks to the store by him or herself). A clash of motivations may then ensue due to each person’s desire to achieve a different goal (Ford, 1994).

In such situations, an elder’s active attempts to maintain control or autonomy in the face of disability or limitation may be adaptive (i.e., have the resources to attain the goal and action results in positive outcomes) or maladaptive (i.e., lack the resources to attain the goal, yet persists anyway despite possible negative outcomes) depending upon context. But regardless of
adaptability, how the other partner in the social context responds may result in conflict. An example of this process is situations where an older adult persists, resists, or insists on acting in a particular manner, despite meeting environmental or social resistance. In the frame of goal pursuit, such behavior may be termed tenacious, whereby one is maintaining persistence in the face of challenges or setbacks (Ford & Smith, 2007). When interacting with family members, however, families may view these efforts by elders to achieve goals in light of past relationship conflict or through the lens of their own goals in their relationships and make appraisals of whether they think their older relatives’ behaviors are adaptive or not. Family members may then appraise behaviors as adequate versus inadequate or appropriate versus inappropriate. And, such attributions may accurately reflect elders’ motivations or not. If they do judge elders’ behaviors as inadequate or inappropriate, family members may then subsequently attempt to redirect elders to follow a different course of action. If an elder persists again, however, in his own way or opinion in an effort to reach his goal there is likely to become a lack of collaboration in care (i.e., Berg & Upchurch, 2007; Bodenmann, 1995; Krause, 2003). In such circumstances, given the family member’s position of power with greater ability and access to resources, elders’ attempts to accomplish their goals may be dismissed or negated by accounting for the behavior as the older adult merely acting “stubborn”. Beyond the possible pejorative nature of this term (i.e., “He insists on doing... but he cannot. He is so stubborn!”), this possibly frustrating sequence of behaviors may result in further limitation to the elder’s ability to assert independence (i.e., increase reliance on dependency support scripts; M. Baltes, 1996), or lead to relationship tension, relationship conflict, or decreased well-being for the older adult or family member. Yet, research has yet to explore this particular phenomenon in elders’ relationships in its entirety.
Stubbornness, in particular, has generally been conceptualized as an individual characteristic of a person (Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006) of being “fixed or set in purpose or opinion” (Stubbornness, 2011). It is often equated to synonyms such as rigidity, obstinacy, persistence, or in childhood, as active disobedience, defiance, resistance, or failure to follow instructions (Burket et al., 2006). It has further been discussed (1) as a dimension of agreeableness or a singular word describing a personality type (Caspi, Roberts, & Shiner 2005; Davey, Eaker, & Walters, 2003; Holland & Roisman, 2008; Jensen-Campbell & Graziano, 2001; McCrae & Costa, 1987; 1992; Robinson, 2008), (2) as a classification of children’s personalities, e.g., “demanding; strong-willed”, by their parents (Burket et al., 2006), (3) as a description of adolescents by themselves or others (Buchanan & Holmbeck, 1998; Chen, 2010; Davey et al., 2003), (4) as a risk for negative health outcomes and/or suicide for adults (Kjølseth, Ekeberg, & Steihaug, 2009; Kulla, Sarvimäki, & Fagerström, 2006), (5) as dysfunctional for a healthy marriage (Burpee & Langer, 2005), (6) as a description of psychopathology in the Diagnostic and Statistical Manual (DSM; Coles & Stone, 1972; Fukuda & Matsue, 1980; Wills, 1978), and (7) as a common descriptor within open-ended interviews to describe an individual (Allen, 1999; Berdie, 1940; Demiris et al., 2008; Dong et al., 2011; Metfessel & Lovell, 1942; Ramirez, 2010; Skovdahl, Larsson Kihlgren, & Kihlgren, 2004; Stull, Cosbey, Bowman, & McNutt, 1997). However, in each instance, stubbornness is discussed or studied as a personality trait with only one survey item or the singular descriptive word. Yet, discussions of persistence in goal attainment, such as those presented in relation to control efforts (i.e., primary versus secondary control efforts; Wrosch et al., 2000) and goal pursuit (i.e., tenacity; Ford & Smith, 2007) appear to describe a behavioral sequence of responses. Research has yet to fully investigate the occurrence or consequences of such behavioral episodes such as
that described above where the term “stubbornness” is often applied. An understanding of these issues may be critical to ensuring that autonomy of the elder is honored in balance with security and a family member’s needs.

Ultimately, as adults age they increasingly experience limitation in their behavioral abilities (P. Baltes, 1997; P. Baltes et al., 2005) and are presented with challenges in their environment that they can no longer easily manage (Lawton & Nahemow, 1973). These challenges, in turn, likely increase the occurrence of goal conflict, resulting in relationship tension, as tensions in parent and adult child relationships, in particular, can develop in response to differential needs, such as independence and relationship importance (Fingerman, 1996; Birditt, Miller, Fingerman, Lefkowitz, 2009). Conflicts in care or relationship goals coming out of competing needs for autonomy may result from or lead to a behavioral response of an elder persisting, resisting, or insisting on an outcome. This form of conflict is likely similar to unsolicited advice, affecting one’s sense of cohesion in a relationship and resulting in negative effects on relationship quality and well-being (Birditt, Cichy, Almeida, 2011; Birditt, Miller et al., 2009). Furthermore, how a family member subsequently responds to the situation with an aging individual may also be linked to relationship outcomes such as affective solidarity and ambivalence (Birditt, Rott, & Fingerman, 2009). In specific, employing passive avoidance or active destructive response strategies is linked to decreased solidarity and increased ambivalence, suggesting that the response elicited from a family member by an elder in instances of goal conflict may also carry negative implications (Birditt, Rott, & Fingerman, 2009). Given the articulated importance of supporting autonomy of elders, further understanding of such processes in relationships where a relative provides care or support to an elder is needed in order to more
fully understand the dynamics of goal pursuit and learn how to maximize elders’ well-being and functioning within the context of family relations.

2.4 Conclusions:

In summary, theories of autonomy and control articulate clear benefits of supporting both active and perceived control (Abeles, 2003; Brandtstädter, 1984; Deci & Ryan, 2000; Heckhausen & Schulz, 1995; Pearlin et al., 2007; Wrosch et al., 2000). However, in the context of older adulthood, the expression of such self-directed efforts must shift in focus with declining biological ability. Individuals often must rely more heavily on hidden power or perceived control through secondary attributions and on others through the use of collaborative control (Heckhausen & Schulz, 1995; Krause, 2003; Pyke, 1999). Adaptive responses to one’s environment, resources, and self-abilities such as using selection, optimization, with compensation can allow for the continued expression of self-direction in everyday life (Freund & P. Baltes, 1998; Lang et al., 2011). However, within the context of families, in particular, such adaptation likely comes with a simultaneous reliance on social support and becomes complex, as multiple individuals’ needs and goals must be balanced in relation to one another. Elders’ autonomy needs to be supported as much as possible; however, the values of others involved in providing support and care must also be honored (i.e., autonomy vs. safety). As complex human systems interacting with each other in day-to-day life, individuals must navigate personal needs toward sought after goals simultaneously; multiple members in the same time and space presupposes a great potential for conflict and relationship tension (Ford, 1994). One form of response to goal conflict, understudied, but likely to arise, is in regard to goals in provision of support and care whereby an elder seemingly insists, persists, or resists to try to achieve his
goals. Such behavioral sequences may elicit responses from family members and may be related to negative relationship-based outcomes. However, little is known about how elders influence the care and support they receive in families, particularly through the use of such persistence, resistance, or insistence, i.e., behaviors commonly attributed to stubbornness, in the face of interrelationship goal conflict. In the end, further research is needed to understand this phenomenon in old age and in families with older adults, to improve and advance the care and support we can provide to elders.
Chapter 3. Study 1—Elders’ Influence in Family Care:

Do Daughters Rationalize Restriction of Care Influence for Aging Parents?

3.1 Abstract

Caretakers in nursing homes often use ‘folk logic’, or accounts (e.g., accepted cultural rules) to justify restricting elders’ influence over care decisions when elders’ preferences conflict with facility routines. Research has yet to address if family caregivers similarly restrict elders’ influence in daily decisions where elders’ and caregivers’ preferences in care conflict. Using a sample of 10 dyads (N = 20) of an older adult and adult daughter, we used the constant comparative method to analyze in-depth, semi-structured interview data to investigate how older parents are perceived to influence their daily care, how adult daughters respond to their parent’s influence, and whether daughters employ ‘folk logic’ in response to conflicts in care goals. Results indicate that older adults vary in their involvement in daily care decisions. When there is agreement in preferences about daily care, dyads report tasks generally going well and both individuals’ requests being honored. When there is conflict, however, daughters most frequently try to reason with their parent while elders are most commonly cited to walk away or let their requests go, allowing daughters’ requests to be honored. ‘Folk logics’ were not found consistently across caregivers, yet daughters report making decisions more often in response to health or safety related needs. These data indicate complex patterns of responses by family caregivers and elders to conflicts in daily care-related goals and suggest a need for further exploration of response patterns within families. Such information may prove vital in intervention work to support families caring for an elder at home.
Elders’ Influence in Family Care: 
Do Daughters Rationalize Restriction of Care Influence for Aging Parents?

3.2 Background & Significance

In the context of older adulthood the practice of providing person-centered care, that is in tune with elders’ preferences, is often limited by elders’ loss of physical and social abilities and increasing need for social support (P. Baltes, Freund, & Li, 2005). Caregivers often take on a role with great power for persuasion and decision making in an effort to support elders and do what is ‘best’ for them (Pyke, 1999; Wilkinson, 2001). Yet, as a result, elders’ own views are often not taken into consideration (i.e., Dupuis et al., 2011; Elliott, Gessert, & Peden-McAlpine, 2009; Persson & Wästerfors, 2008). Particularly affected are those who must rely on help with independent activities of daily living (IADLs) and personal activities of daily living (ADLs) in a nursing home or at home (M. Baltes, 1996; M. Baltes & Wahl, 1992). In specific, evidence suggests that caretakers in nursing homes often diminish elders’ influence in care activities on a day-to-day basis through the use of ‘folk logic’ or accounts that elders “can exercise influence only as long as that influence does not conflict with or disrupt the efficient running of the nursing home as a whole” (Persson & Wästerfors, 2008, p. 8). Such a ‘folk logic’ is like the conceptualization of organizational culture, whereby members of an organization have a shared pattern of assumptions for action (Salsbury Lyons, 2009). It provides caretakers with a rationale for action, establishing what is “right, moral or at least acceptable” (Buttny, 1993, p. 49). Findings illustrate that staff use this ‘folk logic’ to dismiss complaints or requests of residents under the pretense that such dismissal of influence is situationally appropriate, oftentimes making the residents’ requests seem trivial (Persson & Wästerfors, 2008).
Similarly, Ulsperger and Knottneurs (2011) propose that everyday rituals (i.e., formal and informal acts with symbolic significance repeated throughout daily life) give insight into situations of abuse and neglect in nursing homes. Like ‘folk logic’ or accounts, rituals help to shape unspoken rules of interaction and are belief systems that individuals rely on to support their actions. In doing so repeatedly, such beliefs create a culture of behavior. For example, in nursing homes, the rituals of bureaucracy and bureaucratic rules dominate practice and care (Ulsperger & Knottneurs, 2011). Care providers will adhere to rules over compassion, allowing rules at times to govern nursing home life as ends in and of themselves. While rules often provide guidance for ‘good’ behavior, reliance on either formal (i.e., safety regulations) or informal rules (i.e., aides act in a way that ‘gets back at’ difficult residents) to justify acting in a way that does not recognize elders’ requests, often keeps residents at a distance, objectifying them (Ulsperger & Knottneurs, 2011). Such behaviors appear to result in residents only being able to attain a particular care request by being a “good match” to the rituals in place (Persson, n.d.). If a resident acts outside of a norm by either disrupting or disturbing the rituals in place, for example requesting a shower not on his ‘shower day,’ his requests are often not accommodated or are postponed and modified (Persson, n.d.). Such a process exemplifies that care is provided but within a contextual framework of institutional culture and psychological belief systems. An institutional model shapes the culture of care and how much an elder can make decisions in his own care and whether his everyday wishes are honored. Based on the consensus that all individuals should have the right to make autonomous decisions when possible in care, that autonomy is an innate need (Deci & Ryan, 2000), and that one’s sense of control is vital to aging successfully (e.g., decreasing mortality while maintaining cognitive performance, health, and well-being; Infurna, Gerstorf, Ram, Scupp, & Wagner, 2010; Jopp & Schmitt, 2010),
such findings in nursing homes are striking. Yet, most pointedly, research has not fully addressed what or if such findings carry implications in regard to informal family caregivers.

A large number of family members are providing care and support to elders in the home (National Alliance for Caregiving & AARP, 2009), and family members are thought to provide compassionate care to their aging relatives with a better working knowledge of elders’ wishes than formal caregivers. However, evidence suggests in some cases as parents become more dependent, relational ambivalence increases for children (Willson, Shuey, Elder, & Wickrama, 2006), children become dominant in decision making for elder parents (Cicirelli, 2006; Morgan & Hummert, 2000; Pratt, Jones, Shin, & Walker, 1989), and/or children influence care decisions or dependency of older adults in care (M. Baltes, 1995; 1996). In particular, research articulates the presence of unique tensions between mother-daughter dyads in regard to perceptions of aging and negotiating care (Fingerman, 1996; McGraw & Walker, 2004). However, a full understanding of how elders exercise autonomy and control and influence the care they are provided in the family context is still lacking. It is unclear whether family caregivers make decisions based on a ‘folk logic’ or ritual in care by utilizing justifications (e.g., accounts) for not honoring the individuals’ wishes or if they exhibit a more compassionate, balanced response to elders’ influence in daily care. Despite the lack of institutional constraints, adult child caregivers are facing constraints of time and resources and therefore may similarly struggle with responding to elders’ influence with a ‘folk-logic’ or take a ritualized approach in some circumstances.

In particular, when family members face conflict in goals of daily care, family caregivers may dismiss elders’ influence in care with accounts that reflect person specific attributes or behavioral outcomes. When an elder attempts to influence care by resisting, insisting, or persisting on acting in a certain way, family members may view these efforts to achieve a goal in
light of past relationship conflict or through the lens of their own goals in care and make an
appraisal of whether they think their relative’s behaviors are adaptive or not. Regardless of the
elders’ true motivations for action, the family member may appraise such behaviors as adequate
versus inadequate or appropriate versus inappropriate. If they do judge the elder’s behavior as
inadequate or inappropriate, family members may then subsequently attempt to redirect the elder
to follow a different course of action (see Figure 3.1 for example of process). If the elder persists
again, however, in his own way or opinion in an effort to reach his goal there is likely to become
a lack of collaboration in care (i.e., Berg & Upchurch, 2007; Bodenmann, 1995; Krause, 2003).
In such circumstances, given the family member’s position of power with greater ability and
access to resources, elders’ attempts to accomplish their goals may be dismissed or negated by
accounting for the behavior as the older adult merely acting “stubborn” (as evidenced in
qualitative narratives: “He is so stubborn; why won’t he just...”; Demiris et al., 2008; Skovdahl,
Larsson Kihlgren, & Kihlgren, 2004; Stull, Cosbey, Bowman, & McNutt, 1997). Beyond the
possible pejorative nature of this term (i.e., “He insists on doing... but he cannot. He is so
stubborn!”), this possibly frustrating sequence of behaviors may result in limitation to the elder’s
ability to assert independence (i.e., increase reliance on dependency support scripts; M. Baltes,
1996), or lead to relationship tension, relationship conflict, or decreased well-being for the older
adult or family member. Accounts of this form may, therefore, be used to dismiss elders’
requests to maintain autonomy and control in care in some instances. Yet, research has yet to
explore the presence and/or use of such accounts that may create a ‘folk logic’ in care by family
caregivers or to determine if families are instead more responsive to the needs of their elders’ in
care.
Thus, given this lack of research and the increasing number of family caregivers providing care for elders, it is necessary to build a thorough understanding of both the meaning and the processes behind elders’ influence in family care through semi-structured interviewing (Maxwell, 1998) with both caregivers and their older relatives. In the end, if families, particularly adult daughters who have unique tensions in their parent-child relationships (Fingerman, 1996), similarly restrict care influence of older adults as caretakers in nursing homes do or struggle with different challenges in allowing elders to influence their care, new adaptive approaches to facilitating more balanced care for elders that honors both individuals’ perspectives may be warranted. In such a case, families are likely to be more amendable to change than formal caregiving systems. Alternatively if families portray more person-centered responses to elders’ influence in care, honoring elders’ influence in balance with caregivers’ needs, techniques may be learned to train professional care staff. Ultimately, such work will inform further research and interventions that may be essential to improving and advancing the care and support we can provide to elders.

The proposed study was modeled after Persson and Wästerfors’ (2008) study and seeks to address the gap in understanding regarding elders’ influence in family care with adult daughters. It addresses three specific aims: (1) determine how elders influence their care in families, (2) explicate how adult daughter caregivers respond to such influence, (3) and understand how adult daughter caretakers respond to elders in the face of goal conflict and account for the way they provide care. More specifically, the study addresses the following questions:

1. How do adult daughters and their aging parents perceive parents’ influence in daily care?
2. How do adult daughter family caregivers respond to daily involvement/influence of their elder parent?
3. Are verbal ‘folk logics’ or accounts employed by adult daughter family caregivers to discount adherence to elders’ preferences, as found in nursing homes (Persson & Wästerfors, 2008)?

4. How do elders and adult daughter family caregivers perceive and respond to conflicts in goals in daily care? Do elders resist or insist on acting in a particular manner? If so, how do family caregivers respond to such behaviors?

3.3 Research Hypotheses

It was hypothesized that elders influence care by acting in accordance with their caregiver’s goals—when the elder’s goals in care match those of the caregiver, their values/needs would be met most readily (Hypothesis 1). Secondly, family caregivers were expected to exhibit compassionate care for their relative and demonstrate efforts of honoring their elder’s wishes (Hypothesis 2). However, when there is a conflict in goals, it was expected that adult daughters would utilize ‘folk logic’ to account for their behaviors that do not match elders’ preferences as situationally appropriate (Hypothesis 3). In particular, adult daughter caregivers were expected to perceive their parents as insisting or persisting (i.e., acting in a way commonly attributed to stubbornness) when care goals conflicted (Hypothesis 4).

3.4 Method

Participants

Ten dyads of an adult daughter (aged 30-62, $M = 51.20$, $SD = 10.10$) and her aging parent (aged 61-90, $M = 79.20$, $SD = 9.09$), to whom she provides at least weekly assistance to, were recruited from a Short-Term Rehabilitation Center. Caregiver was loosely defined to provide for a range of experiences within the sample. The older adult was not required to be of a certain age or have a specific diagnosis, but rather, was required to have no more than mild cognitive
impairment (as deemed by the Center Staff at the recruitment site of having a 13, 14, or 15 total score on the Brief Interview for Mental Status (BIMS) cognition scale) and receive at least weekly assistance with independent activities of daily living (IADLs) and/or activities of daily living (ADLs) from their adult daughter family caregiver (see Appendix A for study sign-up and Appendix B and Appendix C for screeners used). The daughters and parents were not required to be living together but were required to be living in the community (i.e., not in institutional or group living) upon discharge from rehab. As a result, study consent and enrollment commenced approximately one month after discharge from the Center. During the recruitment process, 14 families were referred to the study, 13 screened eligible, and 10 participated. Families who did not participate were no longer eligible at time to schedule \( n = 1 \), passively refused at scheduling \( n = 1 \), and were no longer interested after screening \( n = 1 \).

Restricting this sample to child family caregivers, specifically daughters, allows for more direct comparisons across participants in the data collected, as well as with subsequent survey data collected with a sample of middle-aged adults (Study 2 and Study 3). While such a sample may be biased with dyads that are struggling more, due to recent admittance of the older adult into a Short-Term Rehabilitation Center, data collection was conducted until the point of saturation, whereby little new information was being added to the general themes identified (Kuzel, 1999).

**Procedure**

Upon recruitment, participants \( N = 20 \) received written and oral information about the study and were screened for eligibility. Participants were individually consented to participate and to having their interview recorded. In concordance with the procedures completed by Persson and Wästerfors (2008), participants were interviewed separately at home or in a place
chosen by the interviewee (i.e., coffee shop) without the presence of other individuals if possible. In the case that family members needed to be present, adjustments were made to meet the needs of the participant \((n = 1)\). The researcher conducted an open-ended, semi-structured interview followed by a brief demographic questionnaire. For half of the dyads \((n = 5)\) the adult daughter family caregiver was interviewed first, for the other half the aging parent was interviewed first.

Interviews were audio recorded and transcribed and lasted an average of 49.85 minutes \((SD = 7.94)\). Interviews were loosely structured and began with general questions about perceptions of the care situation. The researcher used a semi-structured guide (Appendix D for adult daughters; Appendix F for aging parents) to facilitate the question and answer process. Upon completion of the semi-structured portion, the researcher completed a basic demographic questionnaire, only reading items that had not already been answered through the open-ended portion (see Appendix E for adult daughter; Appendix G for aging parents). Participants were paid $20 for their time and thanked for their participation.

**Measures**

**Semi-structured interview.** This study used qualitative in-depth interviews informed by questions previously designed and utilized by Persson and Wästerfors (2008) in interviewing nursing home caregivers (see Appendix D). Questions were translated from Swedish to English, pared down, and adapted to only encompass relevant open-ended questions to answer the proposed research questions (i.e., questions about how the caregiver began such work were eliminated). Additional questions needed to address the topic of goal conflict and responses in the face of goal conflict were added. The guide developed for the adult daughter caregivers was then further adapted to create a parallel form for aging parents (see Appendix F). In the interviews, the researcher used follow-up questions to have respondents elaborate upon their
initial answers. The order of questions was not fixed, but dependent on how the family caregiver or elder responded.

The interviews sought to understand how elders influence their care in families, how adult daughter caregivers respond to such influence, and how adult daughter caretakers account for the way they provide care, particularly in the face of goal conflict. Data were collected from adult daughters and their parents to understand both perspectives of the daughter caregiver, the individual that often becomes the surrogate decision maker for the elder later on, and the aging parent. Respondents provided open-ended responses about their overall experience of elders’ influence in care, scenarios of conflict in not seeing eye-to-eye, agreement of seeing eye-to-eye in care, as well as situations of goal conflict where the elder was thought to persist/insist on an outcome or resist or ignore advice or suggestions regardless of possible outcomes. Interviews allowed for an in-depth understanding of the care phenomena within families.

**Demographic questionnaire.** All participants were asked basic demographic questions developed specifically for this study upon completion of the semi-structured portion of the in-person interview (see Appendix E for adult daughters; Appendix G for aging parents). Questions were read aloud to participants if he or she had not previously answered them during the semi-structured portion. For the family caregivers, all individuals were daughters of the person they care for; therefore, gender and kin relationship were not asked. Adult daughters and aging parents were asked to indicate their age, race/ethnicity, marital status, and highest completed level of education from 1 (less than high school) to 6 (graduate degree). Adult daughters were then additionally asked whether they provide any financial assistance to their parent 0 (no) or 1 (yes) and to rate the amount of money they spend on care each month from 1 (about what you can afford) to 3 (much more than you can afford). Lastly, adult daughters were asked to rate
their parents’ level of cognitive impairment using Pearlin’s 7-item cognitive status scale (Pearlin, Mullan, Semple, & Skaff, 1990), as a check to the referral of individuals with no more than mild cognitive impairment. The 7 items asked the adult daughter to rate the difficulty her parent has doing the following: remembering recent events, knowing what day of the week it is, remembering his/her home address, remembering words, understanding simple instructions, finding his/her way around the house, and/or speaking sentences on a 5-point likert scale from 0 (not at all difficult) to 4 (can’t do at all). Items were combined to create a total score of memory impairment ($M = 1.90, SD = 1.66$). Older adults were not self-assessed for their cognitive impairment. (See Table 3.1 for sample statistics)

**Data Preparation and Analysis Plan**

Data were transcribed and checked for accuracy. They were entered into NVIVO, a qualitative coding program (QSR International Pty. Ltd.). Transcripts were read to produce a base coding-tree from the stem interview questions for both the adult daughters and the aging parents, initially using broad codes. The coding schemes were then expanded as common responses were identified throughout the process of analysis. Data were qualitatively analyzed utilizing the constant comparative method (Glaser, 1965), to add codes increasing in specificity according to responses provided. Each interview was coded based on the created schema by an initial trained coder. Two additional trained assistants coded a random subset of interviews to ensure coding reliability ($n = 9; \geq 80 \%$ agreement). Discrepancies between coders were discussed and resolved by agreement. This method of analysis allowed for the examination of daily care influence and the presence of a ‘folk logic’ and accounting strategies (Buttny, 1993) to address the proposed hypotheses. Themes identified within the adult daughter interviews were compared to overall themes identified in the aging parent interviews to determine similarities
and/or differences in responses. The ultimate goal of the analyses was to identify common themes of accounts and responses across caregivers and older adults to answer the proposed research questions.

3.5 Results

Research Question 1—How do elders influence their care?

In regard to the first question, we find that perceptions of older adults’ involvement in care tasks and decision making on a day-to-day basis varied across individuals, from deciding how to spend all of their time and doing just about all of their own daily care tasks to only making decisions in a couple of areas (i.e., such as dressing or waking). Across the sample, elders averaged making 5.2 decisions for themselves, with all 10 dyads reporting elders’ involvement in deciding how to spend their time. Further, participants almost universally referenced a need for the parent to experience independence or autonomy for themselves ($n = 9$ of 10 parents; $n = 10$ of 10 daughters) in making decisions and completing daily tasks.

“No she’s pretty, pretty independent and we try to have her do as much as she can do because we think it’s just best for her mental state. And her, she was always independent, very on the go, and so, umm, you know I think that’s been the hardest part of her getting ill is just that loss of independence.”—Daughter, 1112

“Well I know that she has to let go of me, you know, that I have to be independent. You know I see a lot of women my age who are still, who are not still, who are very much dependent on their children and that I never want to be.”—Parent, 1118

Meanwhile, daughters in this sample reportedly make an average of 4.1 decisions for elders (such as medical and care related decisions) on a day-to-day basis, other individuals (i.e., other children or professional care aids) make an average of 2.5 decisions, and elders and daughters report making an average of 1.3 decisions together (most frequently medical decisions). In these instances parents appear to rely on their daughters or others for their expertise:
“I’m pretty much the decision maker and she knows even though she’s very independent and she likes to be able to, to make all of her decisions, she knows that it’s in her best interests to have me navigate everything. So, ’cause I’ve been, I’ve proved to her many times that I can handle the situation and get her services and get her taken care of and she can trust me, so that, that really works well.”—Daughter, 1111

Thus, their reliance on others was not perceived to limit their abilities, but rather to support them in their care.

Further, within these daily decisions and care when there is agreement in care goals or daily tasks, dyads report things just going well. In accordance with Hypothesis 1 that elders will influence care by acting in accordance with their caregiver’s goals (i.e., when the elder’s goals in care match those of the caregiver, their values/needs will be met most readily), we find that when there is agreement in care the elder’s requests are honored and he or she appears to be enabled to make the decision or work in partnership with his or her adult daughter to make the decision.

“She had this growth on her foot that we’d been watching for a while, and umm, it’s like well, you know we’ll watch it, watch it, watch it, and finally like, we both sort of looked at each other one day and said we got to, ‘We’ve got to deal with this one.' And she’s like, ‘Yep we do.'”—Daughter, 1112

“Now, for instance, yesterday she took all my winter clothes, which she keeps in the next room in big plastic containers. And last year I did it all myself, I put ’em, took all the summer ones out on the bed, put all the winter ones in, folded the other ones, put them away. This year, she brought the boxes in and uh, I said, ‘I can’t do that.’ ‘I know you can’t!’ [Laughs] That’s the first time I’ve raised my voice and so did she, because I knew I couldn’t do it. But, she did every bit of it.”—Parent, 1103

“She’s pretty easy going and like, if she has an appointment and she doesn’t feel up to going, I’m just like, ‘Okay we’ll reschedule,’ you know like, there’s really nothing where she’s so insistent upon it should be her way, that I feel like I have to really have a power struggle with her.”—Daughter, 1109

When there is conflict, however, the responses and influence of the elder vary across families and circumstances. The most common response strategies discussed overall, when referencing a conflict in care goals were reasoning (n = 133 citations within 18 transcripts) and letting go (i.e., walking away from the conflict and letting request go; n = 153 citations within 19 transcripts). The most common strategies discussed for daughters’ behaviors were reasoning (n
= 96) and letting go (n = 71), while for elders it was letting go (n = 82) and continuing to act on one’s own impulses (n = 58). Other response strategies employed included getting upset, arguing, brainstorming a solution, getting someone else to talk to the other individual, using humor, waiting to talk about it another day, and rewording the request (see Table 3.2 for summary of response strategies). Thus, elders most frequently appear to be attempting to influence the outcome when there is conflict by being more passive and relinquishing their request to their daughter’s goal, but also through active attempts to persist in their ways or opinions.

When looking further at descriptions of how relationship tension was resolved, however, the most common form of response utilized that resulted in resolution was letting go (n = 63 citations within 16 transcripts). Families referenced that one or the other individual walked away from the conflict, or let their request go in order to reach a resolution. And although, the aging parents most frequently employed this strategy when facing goal conflicts with their daughters, in regard to discussions around conflict resolutions, both parents and daughters at a sample level appear to step away from the conflict and let it go in equal quantities (Daughters: n = 30 citations; Parents n = 33 citations). Yet, when examining such a process at the more micro level of dyad-by-dyad, we see that there are between dyad differences in how conflicts are resolved, with some elders letting go of their requests more frequently than other elders, and variance in the contexts within which they do so (see Figure 3.2). Thus, elders appear to be influencing care with their involvement in decision making generally and within situations of agreement most overtly. However, in situations of conflict, elders’ may attempt to continue to act on their impulses, but they more frequently influence the outcome by more passive means of letting their request go.
In a parallel lens, all 10 families also discussed daughters’ and elders’ behaviors of complaining about issues in their lives. While complaining could be a form of influence by elders and stem from a point of conflict in some cases, in this sample complaints by elders evoked more responses of problem solving or encouragement by daughters. When an elder was not happy with a given situation and offered a concern/complaint, the daughter could step in and offer a solution or try to empathize with the concern. Such situations were less about navigation around goals and more about problem solving, with elders or daughters complaints being responded to in turn by each other.

“You know she’ll listen and umm, you know, a lot of times we’ll try to make little jokes about it or she’ll commiserate with, ‘You know. I know the clothes, the style of clothes are either young or old,’ things like that and you know. She listens and uh, you know gives me her feedback. Sometimes we agree, sometimes we don’t agree, but you know it’s just, it’s a, it’s more of a conversation than a complaint but you know you’re voicing displeasure or concern or you know frustration with a situation, with somebody that is easy to bounce things off of, as opposed to somebody who is going to give me an argument.”—Parent, 1104

Research Question 2—How do daughters respond to elders’ influence?

The findings articulated above begin to address the second research question of how adult daughter family caregivers respond to daily involvement or influence of their aging parent and how elders perceive their family caregivers’ responses. More specifically, we hypothesized that family caregivers would exhibit compassionate care for their relative and efforts of honoring elders’ wishes (Hypothesis 2), and we see evidence of this. Family caregivers perceived and were perceived as ‘letting go’ in the face of conflict almost as frequently as elders. Furthermore, 9 of the 10 daughters interviewed discussed trying to act in a way that honors the ‘best interests’ for their aging parent.

“He tried [to stand up on his own] at the beginning when he came home but I think he, now he realizes that all of us are looking out for his best interests. And he’s not fighting it like he was before. Yea.”—Daughter, 1117
“Not that I want to push her to do it, but I just think it would just be a better quality of life for her. Talking to people that are her age.”—Daughter, 1119

Thus, while daughters most frequently cite reasoning with their parent when there is a conflict in care goals, they also arguably exhibit compassionate care. They attempt to balance when they reason with their parent with strategies of letting their own requests go to reach a resolution, all with their interpreted ‘best interests’ for their parent in mind.

Research Question 3—Are ‘folk logics’ or accounts employed by daughters?

Daughters also discussed why they respond differentially to their parent when facing a conflict, depending upon the scenario and context. Yet, consistent patterns of ‘folk logic’, as hypothesized (Hypothesis 3), were not found across the sample. Daughters only consistently ‘accounted’ for their behavior when referencing a need for preserving the health or safety of their parent. In these instances they reported stepping in to make decisions or influencing decisions more readily in the face of conflict in goals (n = 9 of 10 daughters).

“Like you know, I don’t, I try to let her do her own thing, like do you know what I mean? Like make her own decisions, ‘cause as long as she doesn’t do anything bad, you know, or hurt herself, or whatever, I don’t have a problem with you know what she wants to do.”—Daughter, 1101

“Safety I guess, yea things like that, things that are safe for her. You know like sometimes I’ll say to her, ‘Why don’t you put some makeup on. It’ll make you feel better, comb your hair, put some lipstick on.’ And she’ll say to me, ‘I don’t feel like it.’ So you know what? ‘Okay,’ that’s not so important, I just do that ‘cause sometimes you do that and it makes you feel better, so I just drop it...I’m like, okay, forget it, it’s not worth yelling, it’s not worth arguing over that. But wearing that thing [safety alarm] is worth arguing over, taking the walker is worth arguing over, getting up and getting your own meals are worth arguing over. And, stuff like that.”—Daughter, 1119

“Yea things related to safety or personal hygiene, like needing the bathroom, and no he’s not just going to soil his pants like that. Umm and things related to therapy, like if the therapist needs him to move his arm even though it hurts, or his leg, or exercises, those things I try not to give up on. I told you a little bit I give in, but that I’ll be much firmer on. Anything else I think should be negotiable or like pick your battles. ‘So let him stay in bed ‘til 10,’ ‘so let him not wear that shirt,’ ‘so let him,’ ‘you know, ‘not eat this and eat that.’ Like, ‘Why, why, give the poor man some freedom,’ you know?”—Daughter, 1108
However, behaviors by daughters in such instances were not perceived as discounting the elders’ values, but rather reflected the idea that daughters see health and safety as paramount in care. Of interest though, elders on the contrary did not talk about their need for safety and only a few referenced their concern for an accident happening \((n = 3 \text{ of } 10 \text{ parents})\). Rather, they were more concerned about being a burden to their adult daughter caretaker \((n = 6 \text{ of } 10 \text{ parents})\). They did not reference a ‘folk logic’ rationale for why their daughter responded in a more active manner at some times compared to others.

Furthermore, the use of ‘folk logic’ by daughters was not consistently present in the sense of using a rule or ritual to justify action regarding constraints that limit response to elders’ preferences as found in nursing homes. Only a few daughters referenced a need to postpone honoring the elders’ request at times to allow them to accomplish another task first \((n = 3 \text{ daughters})\). Rather three-quarters of individuals talked more generally about the daughter’s need to find balance between serving as a caregiver for their parent and fulfilling other obligations in their families and at work \((n = 15 \text{ transcripts})\). For families it appears to be about balancing all the individuals’ needs involved in care:

“You have to realize that there’s, that it’s not just the stress of dealing with the patient, it’s the dynamics of the family and the stress of the whole equation.” –Daughter, 1108

Thus, ‘folk logic’ that accounts for why a caregiver may restrict their parent’s preferences was only present in regard to daughters’ perception of a threat to safety or health. In those situations daughters justified both their need to and action to step in to make a decision.

Research Question 4—Do elders resist or insist on acting in a particular manner and how do daughters respond to such goal conflict?

Last, Hypothesis 4 predicted that adult daughters would perceive their parents as insisting or persisting (i.e., acting in a way commonly attributed to stubbornness) when there is a conflict
in care goals and was confirmed by participants in this study. All 20 individuals cited an example of self-perceiving or perceiving their parent as insisting and/or persisting in acting in their ways in attempting to accomplish a care goal. Further, within scenarios of goal conflict the second most common response by elders was to continue to persist in their ways or opinions (n = 58 citations within 14 transcripts). Yet, individuals differed in the number of instances and topics they described as acting in this manner. They described instances around daily care needs as well as instances around larger decisions, such as moving to a new location. Participants also described forms of general conflict that very much overlapped with descriptions of insistence, persistence, or resistance by the elder (see Table 3.3 for a summary of topics discussed).

Of particular interest, adult daughters reported anywhere from 1 to 8 examples of perceiving their parents as exhibiting such behaviors of insisting, persisting, or resisting advice with a mean of 4.4 instances described by each participant. In total, they described 44 instances, almost tripling the number of instances described by their parents (m = 1.6, n = 16). Thus, daughters appeared more readily able to provide such examples, which may have been a reflection of the frustration evoked by such conflict.

“How do I feel? I feel very frustrated. I feel frustrated for him and I feel frustrated for me.”—Daughter, 1117

“I feel umm, frustrated when I have to explain to her a million times why she has to do it and why she should do it. And then once she listens then I’m like, I’m exhausted by the time she agrees to it; it’s exhausting. But, I’m, I’m happy that she listens after that and does it.”—Daughter, 1119

Daughters’ most common explanations for such behaviors by their parents were forgetfulness (n = 4 daughters) or that this is how their parent has always been (n = 3 daughters). In contrast elders did provide examples of such behaviors but to a lesser extent. And they described acting this way because of issues such as pain or another health concern, because they did not agree with their daughter’s idea, or because they just wanted more information before
they made a decision or responded differently. In a couple of cases the elder reframed the question to explain how and why they act in such a manner, suggesting that perhaps they perceive their actions of persistence or insistence a bit differently than their adult daughters do:

“The word is not ignored. The question is to not accept her ideas. No, I listen and I, I understand what she’s saying, I’m not ignoring her, I’m just, uh, doing what I feel I should be doing. [laughs]”—Parent, 1118

Interestingly, daughters did not account for responding to their parents in a certain way because their parent was being insistent or persistent. Rather, they described such instances as sequences of behaviors where they did not see eye-to-eye that they had to navigate in care and work through. When considering strategies used during a resolution to a situation where the elder was thought to insist in his/her ways or opinions even if it might make his/her life more difficult or unsafe, daughters in this sample were most frequently cited to reason with their elder \( (n = 10 \text{ citations within } 5 \text{ transcripts}) \) versus letting their request go \( (n = 7 \text{ citations within } 2 \text{ transcripts}) \) while their aging parents were most commonly cited as letting their request go \( (n = 12 \text{ citations within } 12 \text{ transcripts}) \). Thus, again, despite initial insistence or persistence, the aging parent often resolved the tension by stepping down from his or her request. Meanwhile, however, the frequency for either member letting their request go to reach a resolution when there is goal conflict was more similar across situations where the elder was thought to ignore advice or suggestions or experience a more general conflict in care (see Table 3.4).

Furthermore, while not prompted directly, a quarter of the sample did overtly use the word “stubborn” to describe themselves (elders) or their parents (daughters) when the elder was perceived as being insistent in these instances.

“It’s ‘cause she’s stubborn and it has to be her way like and she doesn’t like and I’m not the type of person that’s gonna say, ‘Well you’re going to do it my way,’ you know, and I’m not—’Okay fine, we’ll do it your way, ‘cause I’m not the one going in the hospital.’”—Daughter, 1101
While this was not described as a ‘folk logic’ for action to dismiss elders’ requests, it was presented as a rationale for why the aging parent acts the way he or she does.

3.6 Discussion

This study sought to better articulate how older parents influence their daily care, how adult daughters respond to such influence, whether daughters employ a ‘folk logic’ (i.e., justification for action) in responding to elders’ needs, and if aging parents are perceived to resist, insist, or persist in their care goals despite possible consequences. Overall, the findings of this study demonstrate the difficulties aging parents and their daughters experience when navigating care issues and the complex patterns of response these individuals employ on a day-to-day basis in managing care. The results outlined above ultimately further our understanding of how families respond to conflicts in care goals but also raise additional questions to explore in research and practice.

First, elders appear to most commonly influence their care by being involved in daily decision making, finding agreement with their adult daughter caregiver, and through passive response strategies in the face of conflict (i.e., letting their request go). In line with previous work, elders in this study demonstrated diversity in their abilities and expressed variance in their desire to be involved in decision making (Bastiaens, Van Royen, Pavlic, Raposo, & Baker, 2007; Flynn, Smith, & Vanness, 2006). However, all dyads expressed the importance of maximizing the elders’ abilities, independence, and involvement in care. Aging parents further demonstrated influence in care when their requests in care were in agreement with their adult daughter’s as found by Persson (n.d.) in nursing homes. When there was agreement in a goal the elders’ and the daughters’ requests were honored through collaboration. However, when faced with conflict in care goals, elders’ active attempts to overtly achieve a goal-based outcome were often met
with reasoning by the daughter for why their behavior should be re-thought out or re-configured. Elders faced choices in these instances of whether to continue to act on their goal or to step back to avoid further relationship conflict. In such instances, elders most frequently discussed a process of stepping down from their request and letting it go.

At first glance, such responses by elders of letting the conflict and their requests go to allow their daughters’ requests to be honored, seemingly relinquishes elders’ influence in the situation. However, in line with theory and previous research, this may in actuality represent an elders’ attempt to assert secondary control in a tense situation, relinquishing their attempts to overtly control the outcome and instead relying on cognitive interpretations of the situations to reconcile the conflict between one’s goals and the outcome (Heckhausen & Schulz, 1995). In this regard, indirect control strategies could be viewed as more nurturing than no control strategy (Morgan & Hummert, 2000) and could be an effort by the parent to reduce burden on their daughters, a concern that was voiced. Such findings are consistent with prior work that demonstrates that older people are more likely to use loyalty strategies than younger adults (doing nothing or waiting; Birditt & Fingerman, 2005) and that elders often step down and expect families to make long-term care decisions as a means of extended autonomy for that elder (High, 1988). Thus, it may be an adaptive strategy exhibited by elders to step away from tension when there are conflicts in goals.

However, such behaviors could also be interpreted as evidence that the elders’ influence is diminished when daughters’ own needs and preferences for the elders’ situation do not match those of the older parent. Daughters have great power in decision making (Pyke, 1999; Wilkinson, 2001); thus, they may be using that power to influence their elders’ actions and adjust their parents’ goals. The findings from this study are not wholly conclusive in this regard,
However. Further work is needed to examine differences in definitions of what a resolution is or means. For elders, their use of hidden power to act and to let go of their request may carry a different meaning for them in their relationship than it does for adult daughters. While an initial goal for the elder may be a specified outcome (i.e., to have a book picked up from the library), upon meeting resistance, their goal may actually change to just wanting to have a positive interaction with their daughter, thereby changing their action and request. The initial push back on their first goal may no longer matter to the elder, so as a result not carry implications for diminishing their requests. Or as daughters hypothesized, elders’ responses related to goal conflicts could be less cognitive or thought out as hypothesized, and requests to honor differential goals may simply come as a product of forgetting previous decisions discussed or be driven by the elder’s personality that is characterized by lack of openness. Regardless, the evidence here suggests that elders have more passive, hidden power in influencing care outcomes, as compared to a more active, reasoning approach used by daughters.

Secondly, the idea that adult daughters cite a ‘best interests’ perspective is interesting as it may be the reason for why family caregivers act as they do. They appear to be weighing the pros and cons of the possible outcomes of a conflict in care and then acting in a direct manner to evoke a response from their parent. The use of more direct strategies by daughters, such as reasoning found in this study, are perceived as more effective for addressing elders’ (over the age of 70) problem behaviors (Morgan & Hummert, 2000). Further, daughters appear to practice flexibility in determining if the perceived negative outcome outweighs the possible benefit of the elder making his/her own choice or decision and responding accordingly on a situation-by-situation basis. This is in contrast to formal caregivers, where the ‘best interest’ is often defined by the institution’s rules to preserve safety and institutional efficiency (Ulsperger & Knottneurs,
When daughters feel it is a health or safety-related issue they step in, which is consistent with previous research that daughters’ influence their aging mothers’ care with major health, finance, and housing decisions (Pratt et al., 1989). While the true benefit of having daughters step in to make such decisions as opposed to letting an elder fully act on his or her preferences or goals remains to be seen, it does reflect a compassionate response potentially based in worry by daughters to support elders’ life.

However, given that the literature demonstrates significant discrepancies between elders and their family members in understanding elders’ preferences (i.e., Carpenter, van Haitsma, Ruckdeschel, & Lawton, 2000; Fagerlin, Ditto, Hawkins, Schneider, & Smucker, 2002; Reamy, Kim, Zarit, & Whitlatch, 2011), the findings here support a need for further examination of what the elder would define as his or her own ‘best interests’. If elders in fact also value preservation of their lives and choose not to risk their health and safety, then these daughter caregivers are helping to buffer against those environmental risks. But if elders put precedence on the value of doing or deciding as much as possible for as long as possible, over pure life, room for intervention exists, as the conflict of daughters exerting undue influence may lead to negative individual and relationship-based outcomes (Rook & Ituarte, 1999). In particular, in this sample it appears that daughters do not want their parents taking risks, while parents do not want to be a burden; such differences in goals likely leads to misunderstanding. Intervention-based work may help families navigate the discussion of shared versus non-shared values and the issues around safety versus autonomy and what is best for their family. In some cases the honoring of autonomy or the elder’s preferences may need to take precedence over this concern for health and safety (Kane, 1995). Dyadic-based interventions such as those completed by Whitlatch and colleagues with individuals with dementia (Whitlatch, Judge, Zarit, & Femia, 2006) or adaptive
interventions designed to address a family’s unique challenges and risks (Zarit, Femia, Kim, & Whitlatch, 2010) may be able to help all parent-daughter dyads understand each others needs, response strategies, and goals to reduce the occurrence of such frustrating sequences of goal-conflict in care.

Third, in discussing influence of elders in their care, the findings of this study also demonstrate that aging parents are often perceived to persist, insist, or resist (i.e., act in a way that is commonly attributed to stubbornness) in the face of goal conflict. Though the contexts for providing care were drastically different across the sample, from caring for an elder physically incapacitated by stroke in the home to providing care to elders that live independently with little support, the issues were similar. All families described instances where parents initially try to influence care with persistence, insistence, or resistance, then either let go, or continue to persist in their request. Such conflicts in care goals in and of themselves are frustrating and result in tension between adult daughters and parents that needs to be resolved. The initial behaviors by elders lead to a series of responses by both family members that affect how the day goes. These behaviors and responses may thus carry important implications for how family dyads function holistically, regarding daily stress (Pearlin, Liberman, Menaghan, & Mullan, 1981) or relationship closeness or quality (Birditt, Miller, Fingerman, Lefkowitz, 2009; Rook & Ituarte, 1999). Further examination with more statistically rigorous analyses with quantitative data may lead to a better understanding of the relationship of such behaviors with other constructs.

What we can take away from the results here is that adult daughters describe more instances of elders persisting or insisting on their goals than elders self-report. Such a finding lends credence to the hypothesized description of response patterns to goal conflicts described in
the introduction. Adult daughters make an attribution of their parents’ actions as appropriate or inappropriate and act in response to such a perception. In particular, daughters’ use of rationalizing their own influence in care when they perceive a threat to safety or health supports this idea. Just the presence of this perception warrants further investigation.

In the end, the family caregiving context, more so than the professional care context, appears to be characterized by a give and take in balancing the preferences and goals of caretakers and elders. Families are unique in that they navigate providing care for elders in light of past, present, and future relationships that they seek to nurture and sustain. They further differ in their inherent flexibility in decision making that is not governed by bureaucratic rules. However, families still report challenges in figuring out how to work through differences in care values and goals. As described, intervention approaches that provide extra family support in problem solving may prove useful to all families.

While this work is limited by its small, homogeneous sample that prevents use of advanced quantitative statistical analyses, this in-depth study begins to address from the ground up how elders and their family caretakers see the older adult influencing care—what decisions are made by whom and how daily conflict in care goals is navigated. Such work informs our more micro-level understanding of the roles family caregivers and elders play in governing care outcomes. This preliminary work sheds light on our understanding of individuals’ strategies for responding to conflicts in care goals and perceptions around elders’ behaviors to insist, persist, or resist in care (i.e., behaviors commonly attributed to stubbornness), which carry implications for our understanding of how care is delivered. Findings from this study highlight in particular the possible need for interventions to more pointedly discuss with families strategies in navigating conflicts in goals around safety and independence. Further inquiry of these ideas, particularly
the consequences of older adults’ actions when there is a conflict in goals and adult children’s responses to such behaviors, is necessary to determine the implications for personal well-being and relationship-based outcomes (i.e., relationship quality). Ultimately, these day-to-day behavioral episodes build and form the framework for family relationships and our understanding of them may be key in supporting and sustaining family caregiving in the home.
Table 3.1

Sample descriptive statistics

<table>
<thead>
<tr>
<th></th>
<th>Daughters</th>
<th></th>
<th>Parents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M/N</td>
<td>SD/%</td>
<td>M/N</td>
<td>SD/%</td>
</tr>
<tr>
<td>Age</td>
<td>51.20</td>
<td>10.10</td>
<td>79.20</td>
<td>9.09</td>
</tr>
<tr>
<td></td>
<td>(Range: 30-62)</td>
<td>(Range: 61-90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>10</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/Partner</td>
<td>6</td>
<td>60.0</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>30.0</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Never Married</td>
<td>1</td>
<td>10.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
<td>50.0</td>
</tr>
<tr>
<td>Education</td>
<td>5.50</td>
<td>0.85</td>
<td>4.30</td>
<td>1.06</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
<td>30.0</td>
</tr>
<tr>
<td>Some College Coursework</td>
<td>2</td>
<td>20.0</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>College Graduate</td>
<td>1</td>
<td>10.0</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>7</td>
<td>70.0</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Employed</td>
<td>8</td>
<td>80.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Provides financial assistance to Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>70.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>30.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>About what can afford</td>
<td>1</td>
<td>10.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Somewhat more than can afford</td>
<td>1</td>
<td>10.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Much more than can afford</td>
<td>1</td>
<td>10.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>N/A</td>
<td>7</td>
<td>70.0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Memory Problems</td>
<td>--</td>
<td>--</td>
<td>1.90</td>
<td>1.66</td>
</tr>
</tbody>
</table>
### Table 3.2

Response strategies employed by adult daughters and aging parents when experiencing goal conflict in their day-to-day relationship

<table>
<thead>
<tr>
<th>Response Strategy</th>
<th>Daughters</th>
<th>Parents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Let it go or apologize, and walk away</strong></td>
<td></td>
<td></td>
<td>153</td>
</tr>
<tr>
<td>‘I’m just fine right here in my apartment. I have my movies to watch, and I watch my soap opera in the afternoon and I have everything I need right here.’ [Laughs] And then you know, okay step away from this one [Laughs]…Yea there’s no point, and I mean, I don’t, I certainly don’t want to argue with her and I mean there are just some people who you know are more, more loners than others and I just have to accept that’s the way she is. –Daughter, 1113</td>
<td>71 (n = 17)</td>
<td>82 (n = 19)</td>
<td>153</td>
</tr>
<tr>
<td><strong>Reason with other or talk it out</strong></td>
<td></td>
<td></td>
<td>133</td>
</tr>
<tr>
<td>And I put my foot down, I said, ‘That’s not, that’s not possible, I can’t even get there, you know in a short amount of time.’ So there has to be somebody 7 days a week and there has to be somebody 4 days double time and that’s what…the nurses have assessed. –Daughter, 1111</td>
<td>96 (n = 17)</td>
<td>37 (n = 16)</td>
<td>133</td>
</tr>
<tr>
<td>Sometimes she gets annoyed with me because I’ll say to her, ‘You know mom, it’s not in your best interests to be doing this.’ And I explain why and, ‘I really would like to talk to the doctor about this.’ –Daughter, 1113</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continue to act on own ideas or behaviors</strong></td>
<td></td>
<td></td>
<td>107</td>
</tr>
<tr>
<td>We just keep butting heads it doesn’t get nasty. It doesn’t get mean. It just gets like whose going to hold their ground, yea, whose going to hold their ground the longest. Yea. Growing up it got nasty, but as adults, it doesn’t. –Daughter, 1117</td>
<td>49 (n = 13)</td>
<td>58 (n = 14)</td>
<td>107</td>
</tr>
<tr>
<td><strong>Argue or yell</strong></td>
<td></td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>Maybe I didn’t when I was little, but I’m not little anymore, so I do [argue/yell]. –Daughter, 1119</td>
<td>24 (n = 12)</td>
<td>37 (n = 12)</td>
<td>61</td>
</tr>
<tr>
<td><strong>Get upset</strong></td>
<td></td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>She’s not happy. She would like me at this point to go into a facility while, you know, while I can still choose what I want, but I’m far away from that. –Parent about daughter, 1118</td>
<td>21 (n = 10)</td>
<td>25 (n = 17)</td>
<td>46</td>
</tr>
<tr>
<td>Brainstorm a new strategy to accomplish request</td>
<td>12 ((n = 8))</td>
<td>I’m like, ‘Yea, but not really, let’s look at it’, you know and so we’ll, I’ll kind of, try to take a step back. And say, ‘Well, so if you’re out on, you know you’re going to be out on Tuesday, your doctor’s appointment’s two hours, check the movie schedule the day before, maybe you go from the doctor’s office to the movies.’ –Daughter, 1112</td>
<td>12 ((n = 6))</td>
</tr>
<tr>
<td>Wait and ask again later or another day</td>
<td>12 ((n = 7))</td>
<td>[Laughs] Sometimes everybody just goes to their own room [Laughs]. Walk away from it, I mean I just walk away from it until the next morning and then just start over again. –Daughter, 1119</td>
<td>8 ((n = 4))</td>
</tr>
<tr>
<td>Use humor to distill tension</td>
<td>7 ((n = 3))</td>
<td>And this time around, I tried very hard to not argue too much with her. And rather, just made a joke, ‘Oh okay, good you could use a third or fourth short sleeve blue blouse, I’ll put it in the short sleeve blue blouse section of the closet,’ you know and so we’re both laughing, joking, it’s funny. –Daughter, 1107</td>
<td>6 ((n = 4))</td>
</tr>
<tr>
<td>Re-word the request differently</td>
<td>8 ((n = 4))</td>
<td>And, I just try to do it in a way that I remind her or I just make a suggestion and she’s more receptive to that then somebody telling her, ‘You need to do this and you’re not doing this.’ –Daughter, 1113</td>
<td>1 ((n = 1))</td>
</tr>
<tr>
<td>Get someone else to ask</td>
<td>6 ((n = 3))</td>
<td>It’s almost like she has to validate what I say. Like not with everything but like something like that. Like I was making her walk, like I, she didn’t really need exercise. Well when the therapist came and said, ‘Yea, this is not far and there’s no reason why you can’t maneuver this, ‘cause you’re going to make that knee stiffer than you’ll never be able to walk again.’ So that’s where the therapist, you know. –Daughter, 1113</td>
<td>0 ((n = 0))</td>
</tr>
<tr>
<td>Other</td>
<td>14 ((n = 11))</td>
<td></td>
<td>8 ((n = 8))</td>
</tr>
</tbody>
</table>

Note. All numbers represent the number of citations of the response strategy throughout all the transcripts; the values for \(n\) represent the number of transcripts the response strategies were cited in for daughters or parents respectively. For purposes of confidentiality, ID numbers were changed throughout this table and paper for families to not be identifiable.
Table 3.3

Described situations of goal conflict

<table>
<thead>
<tr>
<th>Daughters’ Reports</th>
<th>Parents’ Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conflict Description</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td>Elders’ insisting on acting a particular way:</td>
<td></td>
</tr>
<tr>
<td>Insistence on doing physical activity (i.e., doing something cannot do, overexerting oneself, not using walker)</td>
<td>5</td>
</tr>
<tr>
<td>Resistance to moving (i.e., to a smaller home, to assisted/independent living, to a nursing home)</td>
<td>5</td>
</tr>
<tr>
<td>Resistance to using or wanting a safety alarm</td>
<td>2</td>
</tr>
<tr>
<td>Insistence on specific meal choices or preferences</td>
<td>2</td>
</tr>
<tr>
<td>Insistence on having something done (i.e., blanket moved, picking up yarn, picking up books)</td>
<td>2</td>
</tr>
<tr>
<td>Insistence on having a bathroom commode in room</td>
<td>1</td>
</tr>
<tr>
<td>Insistence on being okay home alone</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to medical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to clean out house and give things away</td>
<td>1</td>
</tr>
<tr>
<td>Insistence on keeping multiples of things</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to changing bank account</td>
<td>1</td>
</tr>
<tr>
<td>Insistence on having a bathroom commode in room</td>
<td>1</td>
</tr>
<tr>
<td>Insistence on cooking (i.e., elder using the stove)</td>
<td>1</td>
</tr>
<tr>
<td>Insistence on being okay home alone</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to medical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Elders’ ignoring advice or suggestions:</td>
<td></td>
</tr>
<tr>
<td>Advice for elder to move (i.e., to a smaller home, to assisted/independent living, to a nursing home)</td>
<td>4</td>
</tr>
<tr>
<td>Advice to use a safety device (i.e., bars on bed, a walker)</td>
<td>3</td>
</tr>
<tr>
<td>Advice to use a safety alarm</td>
<td>2</td>
</tr>
<tr>
<td>Advice for elder to not push self physically</td>
<td>2</td>
</tr>
<tr>
<td>Advice to reconcile conflicts with other family members</td>
<td>1</td>
</tr>
<tr>
<td>Advice to use a specific bathroom in the house</td>
<td>1</td>
</tr>
<tr>
<td>Advice to use a different chair</td>
<td>1</td>
</tr>
<tr>
<td>Advice to switch doctors</td>
<td>1</td>
</tr>
<tr>
<td>Advice for specific therapy treatments</td>
<td>1</td>
</tr>
<tr>
<td>Advice for elder to get out of the house for social and/or recreational activities</td>
<td>1</td>
</tr>
<tr>
<td>Advice to clean out house and give things away</td>
<td>1</td>
</tr>
<tr>
<td>Advice to call in a maintenance request</td>
<td>1</td>
</tr>
<tr>
<td>General relationship conflict:</td>
<td></td>
</tr>
<tr>
<td>Elder not getting out of the house or engaging in social and/or recreational activities</td>
<td>5</td>
</tr>
<tr>
<td>Elder's spending habits</td>
<td>4</td>
</tr>
<tr>
<td>Conflict with other family members</td>
<td>4</td>
</tr>
<tr>
<td>Elder's ability to drive (i.e., daughter not wanting elder to drive, but elder wanting to drive)</td>
<td>2</td>
</tr>
<tr>
<td>Elder not wanting extra support from aids</td>
<td>2</td>
</tr>
<tr>
<td>Getting elder's room set up for comfort (i.e., temperature control, safety supports)</td>
<td>2</td>
</tr>
<tr>
<td>Elder's personal care (i.e., nail care, hair care)</td>
<td>2</td>
</tr>
<tr>
<td>Lack of understanding of elder's abilities (i.e., elder wants something that daughter feels elder can do by self, elder says can't do something that daughter feels he/she can)</td>
<td>2</td>
</tr>
<tr>
<td>Decisions around pet care</td>
<td>2</td>
</tr>
<tr>
<td>Concern</td>
<td>N</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Elder wanting something done that daughter feels is more than she can do</td>
<td>2</td>
</tr>
<tr>
<td>Elder's inability to reason logically</td>
<td>1</td>
</tr>
<tr>
<td>Elder not believing daughter about what happened</td>
<td>1</td>
</tr>
<tr>
<td>Elder not wanting to be a burden</td>
<td>1</td>
</tr>
<tr>
<td>Elder raising an opinion when not asked</td>
<td>1</td>
</tr>
<tr>
<td>Elder giving away heirlooms while still living</td>
<td>1</td>
</tr>
<tr>
<td>Elder's efforts to transfer from chair to a toilet/bed, etc.</td>
<td>1</td>
</tr>
<tr>
<td>Elder traveling south for the winter</td>
<td>1</td>
</tr>
<tr>
<td>Miscommunication around expectations for care</td>
<td>1</td>
</tr>
<tr>
<td>Elder being passive in care decision making</td>
<td>1</td>
</tr>
<tr>
<td>Elder moving (i.e., to a smaller home, to assisted/independent living, to a nursing home)</td>
<td>1</td>
</tr>
<tr>
<td>Elder not taking care of home finances/bills</td>
<td>1</td>
</tr>
<tr>
<td>Elder's lack of engagement in conversation</td>
<td>1</td>
</tr>
<tr>
<td>Where daughter puts things when cleaning</td>
<td>1</td>
</tr>
<tr>
<td>Elder's lack of cleanliness</td>
<td>1</td>
</tr>
<tr>
<td>Preferences around what elder wears</td>
<td>1</td>
</tr>
<tr>
<td>Elder's resistance to cleaning out house and giving things away</td>
<td>1</td>
</tr>
<tr>
<td>Elder's habit of clipping coupons</td>
<td>1</td>
</tr>
<tr>
<td>Daughter giving elder too much food</td>
<td>1</td>
</tr>
<tr>
<td>Who daughter is involved with</td>
<td>1</td>
</tr>
<tr>
<td>Where elder stays after receiving rehab</td>
<td>1</td>
</tr>
<tr>
<td>Elder raising an opinion when not asked</td>
<td>1</td>
</tr>
<tr>
<td>Elder’s resistance to planning for future care</td>
<td>1</td>
</tr>
<tr>
<td>Elder not speaking up when not feeling well</td>
<td>1</td>
</tr>
<tr>
<td>Elder traveling south for the winter</td>
<td>1</td>
</tr>
<tr>
<td>Elder's spending habits</td>
<td>1</td>
</tr>
<tr>
<td>Elder moving (i.e., to a smaller home, to assisted/independent living, to a nursing home)</td>
<td>1</td>
</tr>
<tr>
<td>Daughter overly worries</td>
<td>1</td>
</tr>
<tr>
<td>Elder cooking (i.e., elder using the stove)</td>
<td>1</td>
</tr>
<tr>
<td>Where daughter puts things when cleaning</td>
<td>1</td>
</tr>
<tr>
<td>Daughter trying to tell elder how to act</td>
<td>1</td>
</tr>
<tr>
<td>Preferences around what elder wears</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. N refers to the number of individuals, daughters or parents respectively, who cited the given concern.
Table 3.4

Response strategies employed by adult daughters and aging parents when resolving a conflict or tension in their day-to-day relationship

<table>
<thead>
<tr>
<th></th>
<th>When parent insisting on acting a certain way</th>
<th>When parent ignoring advice or suggestions</th>
<th>When general conflict</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daughter</td>
<td>Parent</td>
<td>Daughter</td>
<td>Parent</td>
</tr>
<tr>
<td>Let it go or apologize, and walk away</td>
<td>7</td>
<td>12</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Reason with other or talk it out</td>
<td>10 (5)</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Continue to act on own ideas or behaviors</td>
<td>5 (3)</td>
<td>2</td>
<td>2</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Argue or yell</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Get upset</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Brainstorm a new strategy to accomplish request</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wait and ask again later or another day</td>
<td>3 (2)</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Use humor to distill tension</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Re-word the request differently</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Get someone else to ask</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note. Numbers in cells represent the number of citations of a response strategy in discussion about conflict resolution. Numbers in parentheses indicate the number of transcripts the citations were embedded in when the number of transcripts did not match the number of citations, i.e., transcripts contain more than one of the given citations.
Figure 3.1

*Pattern of response to goal conflict in care*

*Note: Resistance refers to a conflict in care or relationship-based goals*
Figure 3.2

*Example patterns of responses to goal conflict in care*

(a)

She’ll say, ‘Oh well you know, can’t you go to the library and get me these books,’ and I said, ‘Mom I can’t go because I need to, you know the weather’s turned bad, I need to go get some food and things like that.’ Like she may not realize what’s going on outside to drive in, and I’ll say, ‘The library’s in the total opposite direction.’ Like so, like if I explain things to her, she’s pretty much, ‘Right.’ – Daughter, 1101

I usually come back and explain why it could be a problem going forward. ‘If your walker’s across the room, you don’t have your life alert on, and you lose your balance and fall, if you have the life alert on,’ it immediately if they don’t get an answer when they call her name they send an ambulance. ‘If you don’t have it on you’re gonna lay there until I get home.’ And then she, ‘I know, I know, I’ll try to remember to wear it.’ – Daughter, 1113

(b)

Well uh when they talked to me about going home, about leaving rehab I said, ‘I’m going home.’ And she said, ‘No, you’re not, you’re going to my house’. And I said, ‘You know I’m not, I’m going home.’ And I came home. – Parent, 1118

They wanted me in a home. And I won’t go. And they wanted me there before I would be in uh, um really assisted living. They wanted me to sell the house and buy a place, in a home and I fought that to a point where, they don’t mention it anymore, ‘cause they know I’m not gonna do it. – Parent, 1110

*Note: Resistance refers to a conflict in care or relationship-based goals*
Chapter 4. Study 2—“He is so stubborn!”—Adult Children’s and Aging Parents’ Perceptions of Elders’ Persistence, Insistence, and Resistance

4.1 Abstract

Instances of goal conflict in relationships between adult children and aging parents can result in older adults insisting, resisting, or persisting in their ways or opinions, acting in a way commonly attributed to stubbornness. Such response patterns by elders, or the perception of such by family members, may be negatively linked to relationship functioning and challenge the ability of elders to exert autonomy in their daily lives. However, research has yet to examine if, or how frequently such behaviors occur and what factors are associated with such occurrence. With a sample of 88 dyads of middle-aged adults and their aging parents who were interviewed as a component of a larger multi-stage survey study, we examined the prevalence of middle-aged children’s and parents’ self-reports of behaviors that are commonly attributed to stubbornness, their association with individual and relationship-based characteristics, and concordance across reporters. Using descriptive statistics, correlations, regressions, and multi-level modeling we found that over 90% of both middle-aged adults and their aging parents report parents acting in a way commonly attributed to stubbornness. Children’s reports of parents’ stubbornness are related to children’s use of avoidant coping responses in times of relationship conflict, stressfulness experienced in helping parents, parent gender, parent neuroticism, and parent disability. Meanwhile parents’ self-reports of behaviors commonly attributed to stubbornness are related to their child’s level of education, their own level of education, and the support they report providing to their adult children. Furthermore, we found that adult children report higher levels of parent stubbornness than aging parents self-report. Such discrepancy is associated with children’s use of avoidant coping responses in times of relationship conflict, parent gender, parent disability, and parents’ reports of the support they provide to their adult child. These findings carry important implications for understanding how older adults relate to their adult children. This novel exploration demonstrates that both child and parent individual and relationship-based factors are linked to the perceived expression of stubbornness by parents and that there is discordance in perceptions within families. Findings support a possible need for intervention to increase understanding within families.
4.2 Background & Significance

Autonomy and control are innate psychosocial needs of individuals throughout their lifespan (Deci & Ryan, 2000; Heckhausen & Schulz, 1995). However, as adults age, they are increasingly presented with challenges in their environment that they can no longer easily manage (Lawton & Nahemow, 1973) due to limitations in biological abilities and decreased efficacy of cultural resources (P. Baltes, 1997; P. Baltes, Freund, & Li, 2005). Elders’ ability to maintain self-direction in their life is threatened, as the effects of their efforts to directly act on their environment become more limited. To adapt, older adults must relinquish primary control (i.e., directly acting on one’s external environment to change an outcome) and increase their reliance upon secondary control (e.g., coping responses directed at oneself to change cognitive processing around events such as expectation biases, shifts in goals, or attributions of outcomes; Heckhausen & Schulz, 1995) and external supports. In particular, they must turn to the social support of others and often do so in times of decision-marking and when responding to stressors such as illness or disability (Berg & Upchurch, 2007; Pescosolido, 1992).

However, the process by which this shift occurs appears complex. There is ultimately a balance that elders must achieve between becoming dependent on others (M. Baltes, 1995, 1996; M. Baltes & Wahl, 1992) and continuing to persist in desired goals to maintain positive effects of autonomy (i.e., improved social and cognitive functioning, health, well-being, and decreased mortality; Infurna, Gerstorf, Ram, Scupp, & Wagner, 2010; Jopp & Schmitt, 2010; Langer, 1983). In the context of family relationships this shift in reliance on others, where elders must change how they exercise control from more overt efforts to efforts relying more on hidden
power (Pyke 1999) and collaborative control (Krause, 2003), is likely a time of increased risk for tension and conflict in their relationships with close family members. As one person’s goals develop, they may not match the goals of the other partner involved in providing care or support. In such cases a family member may hope to offer support in accomplishing a task (i.e., take the elder to the store), however, the elder may not share this same goal and prefer to accomplish this task in another way (i.e., walking the three blocks to the store by him or herself). A clash of motivations may then ensue due to each person’s desire to achieve their own goal (Ford, 1994).

In such situations, an elder’s active attempts to maintain control or autonomy in the face of disability or limitation may be adaptive (i.e., have the resources to attain the goal and action results in positive outcomes) or maladaptive (i.e., lack the resources to attain the goal, yet persists anyway despite possible negative outcomes) depending upon context. But regardless of adaptability, how the other partner in the social context responds may result in relationship conflict or tension.

Tensions in parent and adult child relationships, in particular, can develop in response to differential needs, such as independence and relationship importance (Fingerman, 1996; Birditt, Miller, Fingerman, Lefkowitz, 2009). Conflicts in care or relationship goals coming out of competing needs may result from or lead to a host of behavioral responses by an elder or child. However, of interest is an older adults’ response of continuing to act on his/her goals when meeting resistance from another person or his/her environment by persisting, resisting, or insisting on an outcome or being perceived as such, or acting in a way that is often attributed to stubbornness. This behavior of persistence when there is goal conflict is likely similar to the tension of unsolicited advice, affecting one’s sense of cohesion in a relationship (Birditt, Miller et al., 2009). Its presence may affect how support can be and is provided to elders, and how
elders influence relationships or support outcomes. However, instances in relationships with family members where goals do not match and elders are thought to resist, persist, or insist are not well understood.

More specifically, in the family context, individuals may view elders’ efforts to persist, insist, or resist in light of past relationship conflict or through the lens of their own goals in their relationship or care and make an appraisal of whether they think their relative’s behaviors are adaptive or not. The family member may then appraise the behaviors as adequate versus inadequate or appropriate versus inappropriate. And, such attributions may or may not accurately reflect the elders’ motivations. If family members judge the elder’s behavior as inadequate or inappropriate, they may then subsequently attempt to redirect the elder to follow a different course of action. If the elder persists again, however, in an effort to reach his goal in his own way there is likely to be a lack of collaboration in pursuing goals (i.e., Berg & Upchurch, 2007; Bodenmann, 1995; Krause, 2003). In such circumstances, the family member is likely in a position of power with greater ability and access to resources. And, elders’ attempts to accomplish their goals may be dismissed or negated by children accounting for the behavior as the older adult merely acting “stubborn” (see Figure 4.1 for the process of attribution). Beyond the possible pejorative nature of this term (i.e., “He insists on doing... but he cannot. He is so stubborn!”), this possibly frustrating sequence of behaviors may result in limitation to the elder’s ability to assert independence (i.e., increase reliance on dependency support scripts; M. Baltes, 1996), or lead to relationship conflict or decreased well-being for the older adult or family member. Yet, research has yet to explore this particular pattern of behaviors in elders’ relationships.
We do know that in the frame of goal pursuit the action of continuing to try to overtly act to achieve one’s goals, termed *tenacity*, may be positive, whereby one is maintaining persistence in the face of challenges or setbacks (Ford & Smith, 2007). However, research indicates such strategies are more successful for young adults than for older adults (Wrosch, Heckhausen, & Lachman, 2000), despite some elders’ attempts to persist in pursuit of goals (Freund, 2006). This persistence in pursuing goals, often labeled as “stubbornness,” however, has generally been conceptualized as an individual characteristic of a person (Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006) of being “fixed or set in purpose or opinion” (Stubbornness, 2011). It is often equated to synonyms such as rigidity, obstinacy, persistence, or in childhood, as active disobedience, defiance, resistance, or failure to follow instructions (Burket et al., 2006). It has further been discussed (1) as a dimension of agreeableness or a singular word describing a personality type (Caspi, Roberts, & Shiner 2005; Davey, Eaker, & Walters, 2003; Holland & Roisman, 2008; Jensen-Campbell & Graziano, 2001; McCrae & Costa, 1987; 1992; Robinson, 2008), (2) as a classification of children’s personalities, e.g., “demanding; strong-willed”, by their parents (Burket et al., 2006), (3) as a description of adolescents by themselves or others (Buchanan & Holmbeck, 1998; Chen, 2010; Davey et al., 2003), (4) as a risk for negative health outcomes and/or suicide for adults (Kjølseth, Ekeberg, & Steinau, 2009; Kulla, Sarvimäki, & Fagerström, 2006), (5) as dysfunctional for a healthy marriage (Burpee & Langer, 2005), (6) as a description of psychopathology in previous versions of the Diagnostic and Statistical Manual (DSM; Coles & Stone, 1972; Fukuda & Matsue, 1980; Wills, 1978), and (7) as a common descriptor within open-ended interviews to describe an individual (Allen, 1999; Berdie, 1940; Demiris et al., 2008; Dong et al., 2011; Metfessel & Lovell, 1942; Ramirez, 2010; Skovdahl, Larsson Kihlgren, & Kihlgren, 2004; Stull, Cosbey, Bowman, & McNutt, 1997). However, in
each instance, stubbornness is discussed or studied as a personality trait with only one survey item or the singular descriptive word. Yet, discussions of persistence in goal attainment, such as those presented in relation to control efforts (Wrosch et al., 2000) and goal pursuit (Ford & Smith, 2007) describe a behavioral sequence of responses. An understanding of the occurrence of such behaviors and how they are situated in the greater context of the individuals’ behaviors and relationship characteristics may be critical to ensuring that the autonomy of elders is honored in balance with family members’ needs and goals.

It is likely that perceptions of such behaviors of insistence, persistence, or resistance by an older adult are linked to a series of factors. If elders or family members are less agreeable overall or elders’ self-perceive themselves as having a “stubborn” personality, elders or family members may be less willing to compromise in times of conflict and perceive their parents (or themselves) as persisting, resisting, or insisting more frequently. Further, given the difficulty in balancing dependency with independence for elders with greater disability, more disability and poorer current health may be associated with perceptions of parents’ behaviors of persistence (M. Baltes 1995; 1996). Additionally, greater reports of such a response to goal conflict in relationships are likely related to relationship quality, as found by Birditt and colleagues (2009) regarding cohesion. It is also likely related to the amount of stress the child experiences in providing help to their parent, or even the amount of support each individual provides to each other. Or lastly, such perceptions of parents acting persistently or resistively may be associated with adult children’s beliefs about helping overall such as whether they are helping for solidarity purposes (i.e. to feel closer to him/her) or more for contingency’s sake (i.e., because help was needed), and/or children’s general response strategies when there is more conflict overall (i.e., being more avoidant). Such perceptions may further be related to demographic variables,
neuroticism, or feelings of obligation in providing support. Ultimately, given the scant research on this topic an exploratory approach to teasing out such relationships is needed (See Figure 4.2).

In addition, prior family-based research shows a pattern of discrepancy when considering values and preferences in daily care and at the end of life (Carpenter, van Haitsma, Ruckdeschel, & Lawton, 2000; Fagerlin, Ditto, Hawkins, Schneider, & Smucker, 2002; McCullough, Wilson, Teasdale, Kolpakchi, & Skelly, 1993; Reamy, Kim, Zarit, & Whitlatch, 2011; Uhlmann, Pearlman, & Cain, 1988; Whitlatch & Feinberg, 2003). Similarly there may be a pattern of discordance in interpreting elders’ behaviors in these situations. Thus, it is meaningful to examine the concordance in reports between aging parents and their adult children regarding behaviors commonly perceived as stubbornness of aging parents.

The goal of this study is not to identify whether an individual is “stubborn” (possesses a trait), but rather to understand interactions between elder parents and their adult children whereby an elder is perceived as insisting or resisting despite opposition of the child or their environment and possible negative consequences. This study aims to understand the prevalence of perceptions of older adults as acting resistively and/or insisting on acting in a certain manner, i.e. acting in a way commonly attributed to stubbornness. Furthermore, the project seeks to ground this novel interpretation of such behavioral episodes in the context of other behaviors, thoughts, and feelings inherent to parent-adult child relationships (e.g., support provided, beliefs around providing support, personality, relationship quality) to determine how the perception of such behavior is related to other individual beliefs or characteristics or relationship-based constructs. More specifically the study will address:
1. How often do adult children perceive their parents as insisting or choosing to do something in a particular way when it may not appear to be in an elders’ best interest (i.e., acting in a way commonly attributed to stubbornness)?

2. How often do aging parents’ self-perceive themselves as insisting or choosing to do something in a particular way despite possible consequences?

3. What individual and relationship-based factors are associated with perceptions of elders’ behaviors to insist or resist?

4. How do elders’ self-perceptions correspond to their adult children’s perceptions of such behaviors? If there is a discrepancy in perception between aging parents and their adult children, what individual or relationship characteristics are associated with the discrepancy?

4.3 Research Hypotheses

Hypotheses were based on the general ideas described above and specific variables were tested for their relationship with behaviors commonly attributed to stubbornness in an exploratory fashion, as the literature has not directly addressed this phenomenon in elders’ relationships. First, it was hypothesized that the majority (> 50% of the sample) of middle-aged adult children and aging parents would report perceiving their parents (or themselves) as presenting at least one behavior commonly described as stubbornness (i.e., resisting or insisting on specified behaviors) and that overall prevalence rates would be normally distributed across the sampled population demonstrating variability in prevalence across families (Hypothesis 1). Second, it was hypothesized that children’s perceptions of parents’ “stubbornness” would be negatively related to both children’s and parents’ reports of agreeableness, reports of elder health, reports of support provided, and reports of relationship quality, but positively related to
contingency beliefs about helping, elders’ disability, children’s reported stressfulness in helping their parents, and children’s use of avoidant coping strategies when conflict, as evidenced by significant correlations and coefficients in regression models of prediction ($p < .05$; Hypothesis 2a). Similarly, we predicted that self-reports of stubbornness by parents would be negatively associated with both individuals’ reports of agreeableness, relationship quality, and support provided but positively associated with elders’ self-reports of having a ‘stubborn personality’ (Hypothesis 2b). Direct hypotheses around the association of other constructs (e.g., demographic variables as well as neuroticism, perceptions of solidarity in helping, and feelings of obligation in providing support) with reports of behaviors commonly attributed to stubbornness were not proposed, but were tested in an exploratory fashion (see Table 4.1 for a breakdown of expected relationships). Third, it was expected that elders’ reports of their behaviors that reflect persistence (i.e., behaviors commonly attributed to stubbornness) would be significantly lower than reports by their adult children, as evidenced by significant effects in the dyadic mean (intercept) and discrepancy score (slope) in a null two-level, multi-level model and a positive discrepancy score, indicating that children reported a higher level of such behaviors in parents than parents report for themselves (Hypothesis 3a). Finally, it was hypothesized that this discrepancy of middle-aged adult children reporting more persistence, insistence, or resistance by their parents than their parents self-report would be negatively associated with relationship quality (i.e., lower relationship quality, more over-reporting) and elders’ health (i.e., lower health, more over-reporting), but positively related to parent disability (i.e., greater disability, more over-reporting; Hypothesis 3b). (See the left side of Table 4.1)
4.4 Method

Participants

Participants were 88 dyads composed of a middle-aged adult (aged 45 to 65; 29 males, 59 females) and his/her parent (aged 66 to 91; 24 males, 64 females) who completed a second round of data collection for “The Family Exchanges Study” (see Fingerman et al., 2010). All middle-aged adults and their parents who participated in the initial survey that ran from January through August of 2008 were asked to complete a subsequent telephone survey between January and August of 2013. Potential middle-aged participants (N = 633; 302 men, 331 women) had at least one child over the age of 18, at least one living parent, and reported on exchanges of support within relationships at Wave 1. The middle-aged adults were asked about a total of 868 living parents (325 fathers, 543 mothers) at Wave 1 and a total of 290 living parents at Wave 2 (103 fathers, 187 mothers). Of the parents, 337 (236 mothers, 101 fathers) participated at Wave 1 and were contacted for a subsequent interview at Wave 2. Middle-aged adults also had the opportunity to provide contact information for parents that did not participate in the first wave of data collection. These eligible parents were also contacted (maximum N = 531).

The final number of cases was dependent upon response rate and the number and capabilities of still living parents. Only those middle-aged adults with a still living parent who also participated in the survey were eligible for inclusion in this sample (N = 99 of 289 who completed Wave 2). In addition, a small number (n = 11) of middle-aged adult children had two living parents that they reported on who then also participated in the survey. To remove this limited dependency in the data of multiple reports within one family, one parent was randomly selected from each of these 11 families. As a result, the final sample included 88-paired dyads of an adult child and parent. Overall, this sample includes 13.90% of the middle-aged adults.
contacted \((N = 88\) of eligible 633) and 10.14\% of eligible aging parents \((N = 88\) of maximum 868 parents). The sample of middle-aged adults was 27.3\% \((n = 24)\) African American and 72.7\% \((n = 64)\) non-African Americans. The parents (64 mothers, and 24 fathers) were 26.1\% \((n = 23)\) African American and 73.9\% \((n = 65)\) non-African American. (See Fingerman et al., 2010 for further details on initial sample)\(^1\)

**Procedure**

This study consisted of second-wave telephone interviews utilizing structured survey questions with middle-aged adults and their parents as a component of the larger multi-stage “Family Exchanges Study,” looking at exchanges of varying forms of support in families. Individuals had participated in the larger study five years prior. All interested participants were asked a series of structured survey questions about a range of behaviors, thoughts, and beliefs. The primary purpose of the study was to capture the support exchange patterns among family members. However, in addition, middle-aged adults, whose parent(s) was/were alive, were asked about their perception and response to their mothers’ and/or fathers’ behaviors of resisting or insisting during the second wave of data collection (see Appendix H). The aging parents were also asked about their own self-perceptions of their behaviors and personality characteristics. (See Appendix I)

**Measures**

**Demographics.** Participants were asked to provide information on demographic characteristics. No specific hypotheses about demographic-based characteristics were proposed, but individual level characteristics were tested to account for previously demonstrated relationships with this sample (Birditt, Miller et al., 2009; Fingerman et al., 2010). Demographic

---

\(^1\) Sample numbers will increase when I re-run analyses prior to paper submission for publication review. At that time there will also be more detailed statistics of response rate and retention for the overall sample.
variables were examined in all analyses, including age, ethnicity, gender, education, and income for both middle-aged adults and their parent(s). In the case of high intercorrelations among demographic variables, decisions were made regarding which variables to retain for analyses and entered into all models accordingly (i.e., child race and parent race were highly correlated and therefore not simultaneously entered into each model). Ethnicity was coded as 0 (non-African American) and 1 (African American). Gender was coded as 0 (female) and 1 (male). Education was coded as 1 (no High School) to 5 (Post Graduate; children: $M = 3.56, SD = 1.14$; parents: $M = 2.73, SD = 1.01$). Income was on a scale of 1 (less than $10,000) to 12 (250,001 or more; children: $M = 6.51, SD = 2.66$; parents: $M = 3.17, SD = 1.55$).

**Covariates.** Middle-aged participants reported on their physical health and geographic distance from their parent(s). Parents reported on their own physical health. Models included physical health due to its association with relationship quality (as done in Birditt, Miller et al., 2009) and geographic distance due to its relationship with support provided (Fingerman et al., 2010). Physical health was coded on a scale of 1 (poor) to 5 (excellent; children: $M = 3.39, SD = 0.82$; parent: $M = 2.94, SD = 1.15$). Distance was recorded in number of miles, and as done previously, log-linear transformed due to positive skew (Fingerman et al., 2010).

**Independent measures.**

**Relationship Quality.** Middle-aged adults and their parent(s) were asked 6-items on a scale of 1 (not at all) to 5 (a great deal) consisting of two positive statements (e.g., how much does your father/mother understand you) and four negative statements (e.g., how much does your father/mother criticize you) to develop a mean item score of perceived relationship quality (Fingerman, Chen, Hay, Cichy, & Lefkowitz, 2006). Negative statements were reverse coded and averaged with the positive items to calculate an overall report of relationship quality. Higher
scores indicate higher positive relationship quality. Each parent reported on their perception of relationship quality with their middle-aged adult child and middle-aged adults reported on their parent(s). Mean report by parents was 4.21 ($SD = 0.59, \alpha = .65$). Mean report by middle-aged adults was 4.07 ($SD = 0.65, \alpha = .67$).

**Personality: Neuroticism & Agreeableness.** Adapted from the Midlife in the United States (MIDUS) study (Lachman & Weaver, 1997), this short form for personality assessment asked middle-aged adults and their parent(s) to rate how well each of nine items described themselves using the scale 1 (*a lot*) to 4 (*not at all*). Four items assessed neuroticism (i.e., *moody, worrying, nervous, calm*) and five items assessed agreeableness (i.e., *helpful, warm, caring, softhearted, sympathetic*). Calm was reverse coded for the neuroticism scale and two mean-item subscales were created to account for neuroticism and agreeableness separately for parents (neuroticism: $M = 2.31, SD = 0.68, \alpha = .64$; agreeableness: $M = 3.90, SD = 0.59, \alpha = .60$) and adult children (neuroticism: $M = 2.55, SD = 0.72, \alpha = .72$; agreeableness: $M = 4.04, SD = 0.56, \alpha = .70$).

**Parent’s Self-Report of “Stubborn” Personality.** Parents completed a brief 3-item battery of questions on their own “stubbornness” as a personality trait. Informed by prior literature (Eckstein, 2011; Finney, 1961; McCrae & Costa, 1987), the measure assessed if the elder self-perceives him- or herself as possessing the personality trait of “stubbornness” with two items asked on a scale of 1 (*never*) to 5 (*always*) (i.e., *I have a stubborn streak in me on certain things* and *People can push me just so far and then I have to take a stand*) and one item that asked parents to rate themselves on a scale of 1 (*flexible*) to 10 (*stubborn*; see Appendix I, Questions 5 to 7). The three items were z-scored and summed to calculate a total level of stubborn personality ($M = -0.13, SD = 2.16, \alpha = .55$; see items 5-7 in Appendix I).
**Avoidant coping behaviors in response to relationship problems.** Two-items on a scale of 1 (*not at all*) to 5 (*a great deal*) assessed middle-aged adults’ avoidant behavioral reactions when encountering general interpersonal problems with their parent(s) (e.g., *I accept that there is nothing I can do about the problem*; Birditt, Rott, & Fingerman, 2009; Miller, Fingerman, & Charles, 2009). A mean item score was calculated ($M = 1.83$, $SD = 0.67$, $\alpha = .60$).

**Parent Disability.** Parents’ level of disability was calculated utilizing a 4-item scale completed by middle-aged adults on parent(s) abilities regarding activities of daily living. Items ask about specific limitations in their parents’ daily abilities (e.g., *Does s/he need help with personal care such as bathing and dressing?*) and were coded as 0 (*No*) or 1 (*Yes*). Items were totaled; higher values indicate greater disability ($M = 1.10$, $SD = 1.20$, $\alpha = .69$).

**Beliefs about helping: Solidarity and Contingency.** Middle-aged participants rated five beliefs about helping aging parents on a scale of 1 (*not at all*) to 5 (*a great deal*) at Wave 1 which are broken into two theory-driven subscales: contingency beliefs (3-items; e.g., *helped because they needed my assistance*) and solidarity beliefs (2-items; e.g., *helping is one way to feel closer to him/her*). A mean item score represents the extent one feels he or she should help based on contingency-based criterion ($M = 3.76$, $SD = 1.07$, $\alpha = .75$) or solidarity ideals ($M = 3.56$, $SD = 1.05$, $\alpha = .65$)

**Support Provided.** Total support provided by middle-aged adults to their aging parent(s) and total support provided by aging parents to their middle-aged child were measured utilizing the Intergenerational Support Scale (Fingerman et al., 2010). The scale consists of the mean item score of 7-items for middle-aged adults and 6-items for parents rated on a scale of 1 (*less than once a year or not at all*), 2 (*once a year*), 3 (*a few times a year*), 4 (*monthly*), 5 (*a few times a month*), 6 (*weekly*), 7 (*a few times a week*), to 8 (*daily*), including: emotional support,
technological support (omitted in parent form), practical support, talking about daily events, social support, providing advice, and financial support (see Fingerman et al., 2010 for further details on scale development). Higher scores indicate a greater amount of support provided (middle-aged adult reports for parents: $M = 4.17$, $SD = 1.29$, $\alpha = .83$; parent reports: $M = 3.83$, $SD = 1.20$, $\alpha = .81$).

*Feelings of obligations.* Middle-aged adult children also reported on their perception of obligation to provide support to parents, indicating on a scale of 1 (*never*) to 5 (*always*) how often they believe middle-aged adults should help their parents regarding six support domains: emotional, practical, financial, talking about daily events, socializing, and advice or guidance (Fingerman, Vanderdrift, Dotterer, Birditt, & Zarit, 2011). Adapted from the Longitudinal Study of Generations (Silverstein, Gans, & Yang, 2006), this measure mirrors the Intergenerational Support Measure (see above). A mean item score was calculated to capture the total level of obligation one feels; higher scores indicate higher levels of obligation ($M = 3.89$, $SD = 0.52$, $\alpha = .81$).

*Feelings of Stressfulness.* Middle-aged participants endorsed one item about the extent to which they find helping their parents to be stressful on a scale of 1 (*not at all*) to 5 (*a great deal*; Fingerman, Cheng, Tighe, Birditt, & Zarit, 2012; $M = 2.14$, $SD = 1.14$)

**Outcome measure.**

**Parent Stubbornness Measure.** A pilot measure of parental insistence, persistence, and resistance, i.e., “stubbornness”, was designed to ask a combination of fixed-choice and open-ended questions. Another sample of middle-aged adults ($N = 88$) were asked to provide words to describe a set of parental behaviors and how they respond to such behaviors. Based on frequency of responses and reliability estimates of scales from pilot results, the measure was
pared down to a 22-item questionnaire (11 mother items; 11 father items) investigating the prevalence of and response patterns to reported stubbornness of elders by their adult children (see Appendix H). In addition, a set of parallel questions was prepared for the aging parent to report on their own behaviors (see Appendix I).

The analyses of this study utilize the first four stem questions of this measure. Both the middle-aged participant and their parent(s) were asked the extent to which the parent exhibits a specific type of behavior (e.g., *Does your father/mother ever insist on doing things his/her own way even if it makes his/her life more difficult?*), on a likert scale from 1 (*never*) to 5 (*always*). Items were recoded to have a meaningful 0 (*never*) and two separate total scores were created—adult child report for their parent (*M* = 6.66, *SD* = 3.45, *α* = .81) and parent self-report (*M* = 3.91, *SD* = 2.54, *α* = .65)—to capture frequency of perceived parental stubbornness to be used as the primary outcome variables.

See Table 4.2 for a summary of all variables tested and who reported on each.

**Data Preparation and Analysis Plan**

The first goal of analyses was to understand the prevalence of reports of parents’ behaviors commonly attributed to stubbornness by (1) middle-aged adult children and (2) aging parents. The second goal was to examine the association of relationship and individual-based factors with perceptions of behaviors commonly attributed to stubbornness for both reporters. Lastly, middle-aged adults’ reports and parent reports of the prevalence of parents’ behaviors were examined for concordance and models were run to test the association of relationship and individual-based factors with discrepancy in perceptions.

Data on parents’ insistence, persistence, and resistance (i.e., *stubbornness*) were entered into the SPSS statistical program with all other relevant survey data from the project and checked.
and cleaned for accuracy. To address Hypothesis 1, descriptive statistics were run to understand the prevalence, range, and variance of parents’ stubbornness reported by both middle-aged adult children and aging parents. Scales were then formed, as proposed above, to capture the perception of parents’ stubbornness by middle-aged adults and by aging parents. Second, to begin to address Hypothesis 2a and 2b, reports of stubbornness were correlated with all demographic, covariate, and independent measures to examine the Pearson product-moment correlations of the prevalence of behaviors attributed to stubbornness with proposed factors.

Third, to further address Hypotheses 2a and 2b, reports of stubbornness were then included as outcome variables in two sets of hierarchical linear regression models to further understand what factors are associated with (1) middle-aged adults’ reports of their parents’ insistence, persistence, or resistance, and (2) parent self-reports of such behaviors. Given the exploratory nature of the study with the limited sample size, a parsimonious approach to model building was taken. Only variables that showed zero order correlations that were at least trending \( p < .10 \) with the outcome variable were entered into each model (see Table 4.3; Rovine, von Eye, & Wood, 1988). Additionally, predictors were entered in four steps. First one’s own demographic characteristics were entered into the models (i.e., parent demographics for parent self-reported stubbornness). Non-significant effects were trimmed out. Second, one’s partner’s demographic characteristics were entered into the second step of the models (i.e., child demographics for parent self-reported stubbornness). Non-significant effects were again trimmed out. Third, one’s own individual characteristics were entered into the models, and fourth, one’s partner’s characteristics were entered into the models, trimming after each step. Table 4.4 indicates which variables were included at each step for each outcome variable.
Fourth, multi-level modeling was used to address *Hypotheses 3a and 3b* investigating the concordance in reports of parents’ stubbornness by adult children and aging parents (SAS PROC MIXED; Littell, Milliken, Stroup, & Wolfinger, 1996). Multi-level modeling enables us to predict both the level of the outcome and the level and direction of differences in reports of the outcome within pairs (Maguire, 1999). It further accounts for the interdependence of individuals within each dyad or family. In this case individual reports by parents and children (Level 1) are nested within the family (Level 2). At Level 1 (within-families), we used observations from each individual reporter to fit a regression with two parameters—slope and intercept—on the indicator variable entitled Generation (*G1* or *G2*). The intercept represents the mean level of perceived prevalence of stubbornness reported by each parent/child dyad. The slope captures the degree of discrepancy in the level of reported stubbornness between the dyad members. The indicator variable, Generation, is coded −0.5 for parents (*G1*) and 0.5 for children (*G2*) to allow the intercept to represent a mean across dyad members and the slope to indicate the direction of discrepancy between dyad members. A negative coefficient for discrepancy indicates that parents reported a higher level of stubbornness than children; a positive coefficient for discrepancy indicates that children reported a higher level of stubbornness than parents. The individual score (*Y*<sub>ijk</sub>) for the *i*th member in the *j*th dyad is modeled as:

\[ Y_{ij} = \beta_0 + \beta_1 (\text{Generation}_{ij}) + e_{ij} \]

where there is an intercept (*\beta_0*, the mean score across dyads), a slope (*\beta_1*, the degree of discrepancy between the pair), and individual-level errors of prediction (*e*<sub>ij</sub>). To determine if there are significant differences in reports of stubbornness across dyad members, we examine the dyadic mean (intercept) and discrepancy (*Hypotheses 3a*).

At Level 2 (between-dyads), the intercept (mean score of parent-child reports) and slope
(discrepancy between parent-child reports) are treated as outcome variables, which can vary across dyads. We included here the individual and relationship-based characteristics used to address Hypothesis 2a and 2b that showed a significant association with the difference in reports of parents and children on parent stubbornness to test Hypothesis 3b. Level 2 is then modeled as:

\[
\beta_{0j} = \gamma_{00} + \gamma_{01}W_{qj} + U_{0j} \\
\beta_{1j} = \gamma_{10} + \gamma_{11}W_{qj}
\]

where \( W_{qj} \) are characteristics used as predictors of the effect of \( \beta_{pj} \), and \( \gamma_{p1} \) is the corresponding coefficient representing the direction and strength of association between characteristic \( W_{qj} \) and \( \beta_{pj} \). The error term \( (U_{pj}) \) represents the deviation from the Level 2 group mean that does not vary across dyad members. The variables tested at Level 2 for association with discrepancy were examined in four groups: demographic characteristics of the parent, demographic characteristics of the child, individual and relationship-based characteristics of the parent, and then individual and relationship-based characteristics of the child. As with previous models, the model was trimmed to only retain significant variables after each set of predictors before moving forward (see Table 4.4 for variables tested).

All in all, descriptive statistics, correlations, hierarchical linear regression, and multi-level modeling were utilized to provide an initial response to the research questions posed regarding prevalence of and the differential factors associated with perception of parents’ behaviors commonly attributed to stubbornness by middle-aged adult children and their parents.

4.5 Results

Hypothesis 1 predicted that the majority (> 50% of the sample) of middle-aged adult children and aging parents would report perceiving their parents (or themselves) as presenting at least one behavior commonly described as “stubbornness” (i.e., resisting or insisting on specified behaviors) and that overall prevalence rates would be normally distributed across the sampled
population demonstrating variability in prevalence across families (*Hypothesis 1*). Basic descriptive statistics confirm this hypothesis. As a scale and as individual items the responses are normally distributed across 0 (*never*) to 4 (*always*; see Table 4.5). Furthermore, 95.45% of the sample of adult children endorsed their parent as presenting at least one behavior commonly attributed to stubbornness (*n* = 4 reported no stubbornness) and 90.90% of older parents self-endorsed presenting at least form of stubbornness (*n* = 8 parents endorsed no stubbornness; 21 of 24 fathers endorse stubbornness; 59 of 64 mothers endorse stubbornness).

*Hypothesis 2a* predicted that reports of perceived parent behaviors commonly attributed to stubbornness by adult children would be negatively related to both children’s and parents’ reports of agreeableness, reports of elder health, reports of support provided, and reports of relationship quality but positively related to contingency beliefs about helping, parent disability, children’s reported stressfulness in helping their parents, and children’s use of avoidant coping strategies when there is conflict, as evidenced by significant correlations and coefficients in regressions (*p* < .05; *Hypothesis 2a*). Correlations and regression results confirm that greater use of avoidant coping strategies by children when there is conflict is related to higher reports of perceived parent stubbornness. For each one unit increase in use of avoidant coping behaviors, children report a 0.86 unit increase in stubbornness by their parents. Additionally, children who report that they experience more stress when helping their parent also report higher levels of perceived parent stubbornness. For each one unit increase in stress experienced there is a 0.86 unit increase in stubbornness reported. And, higher report of parent disability is related to higher report of parent stubbornness. For each one unit increase in parent disability there is a 0.89 unit increase in children perceiving their parent as displaying stubbornness. Yet, despite no prediction, we also see that higher report of parent neuroticism is related to higher reports of
parent stubbornness. For each one unit increase in parent neuroticism there is a 1.20 unit increase in perceived stubbornness reported by children. Furthermore, children report higher levels of stubbornness for fathers than mothers. Reports are also significantly negatively correlated with child and parent reported relationship quality and parent physical health, and positively related to contingency beliefs about helping, though these variables were not significant predictors above and beyond the variables accounted for in regression models (see Table 4.3 and Table 4.6). Last, reports of parent stubbornness by children were not significantly related to race/ethnicity, age, education, income, child gender, child physical health, geographic distance, child or parent agreeableness, child solidarity beliefs about helping, child feelings of obligation in helping, child or parent support provided, or parent endorsement of a ‘stubborn personality’. (See Table 4.1 for pattern of regression findings)

Hypothesis 2b predicted that self-reports of perceived stubbornness by parents would be negatively associated with both parents’ and children’s reports of agreeableness, relationship quality, and support provided but positively associated with elders’ self-reports of having a ‘stubborn personality’. Findings indicate that having a ‘stubborn personality’ as reported by parents is significantly positively correlated with parent self-perceived stubbornness, but no other predictors confirmed the proposed relationships. Parent or child relationship quality, parent or child agreeableness, and child support provided were not significantly associated with parents’ self-reported stubbornness. And, parent reports of support provided to children were significantly related to parent stubbornness in the opposite direction as expected, with higher levels of support provided to children related to higher reports of self-perceived stubbornness. For each one unit increase in support provided by parents to their adult child there is a 0.45 unit increase in parent self-reported stubbornness. Additionally, beyond the hypotheses, findings
indicate that higher parent education is related to greater reports of parent self-reported stubbornness. For each one unit increase in education there is a 0.73 unit increase in stubbornness reported. And, higher child education is negatively related to parent self-perceived stubbornness; for each one unit increase in child education level there is a 0.49 unit decrease in parent self-reported stubbornness. Furthermore, parent health is negatively correlated with self-reported stubbornness by parents, and race/ethnicity, age, child or parent gender, income, child physical health, geographic distance, child neuroticism, child avoidant coping responses, child solidarity beliefs, child contingency beliefs, child experienced stressfulness in helping, child support provided to parent, and parent disability were not significantly associated with parents’ self-reported stubbornness. (See Table 4.3 and Table 4.7 for results, and Table 4.1 for the pattern of regression results)

Hypothesis 3a predicted that elders’ reports of stubbornness would be significantly lower than reports by their adult children, as evidenced by significant effects in the dyadic mean (intercept) and discrepancy score (slope) in a null two-level, multi-level model and a positive discrepancy score, indicating that children reported a higher level of stubbornness than parents. Results confirm this hypothesis. There is a significant difference in parent and child reports of parent stubbornness with children reporting more attributions of parent stubbornness than parents-self report (see Table 4.8, Model 1).

Finally, Hypothesis 3b predicted that middle-aged adults’ over-reporting of behaviors commonly attributed to stubbornness would be negatively associated with relationship quality (i.e., lower relationship quality, more over-reporting) and elders’ health (i.e., lower health, more over-reporting), but positively related to parent disability (i.e., greater disability, more over-reporting). Results partially confirm the hypothesis such that current parent disability is
significantly positively related to the mean reports of stubbornness by the dyad (higher disability of the parent, more stubbornness reported) and the discrepancy in reports. Higher reports of disability are associated with adult children reporting more stubbornness than their parent self-reports. The more problems children see their parents as having regarding activities of daily living, the more they over report their parents’ stubbornness. However, results indicate that there is only a trend in the opposite expected direction for relationship quality, toward greater relationship quality reported by children being related to parents self-reporting more stubbornness than children report. Additionally, discrepancy is linked to parent gender (children see fathers as more stubborn than mothers) and parent reported support provided and child use of avoidant coping strategies. More specifically, parent reported support provided to children is negatively associated with discrepancy. Higher reports of parent-reported support provided to child are associated with parents self-reporting more stubbornness than their adult children report. If parents say they give more support to their children they also report more stubbornness by themselves than their children report for them. Meanwhile, children’s use of avoidant coping strategies is positively related to discrepancy. Greater reports of children’s use of avoidant coping strategies when there is conflict in the relationship is related to children reporting more stubbornness than their parents self-report. Thus, if a child reports avoiding conflict they are reporting more stubbornness for their parent than their parent self-perceives. Reports of children’s experienced stress in helping parents is significantly negatively correlated to the difference score of reports of parent and child perceptions of stubbornness, but it only trends toward significance in the tested multi-level model (more child over-report, more stress). Additionally, parent reported relationship quality is positively correlated with discrepancy, but does not have a significant association with discrepancy in the multi-level model (see Table 4.3
and Table 4.8). Race/ethnicity, age, education, gender, income, parent or child physical health, geographic distance, parent or child neuroticism, parent or child agreeableness, child solidarity or contingency beliefs about helping, child feelings of obligation, or parent ‘stubborn personality’ are not significantly associated with the discrepancy.

4.6 Discussion

The results of this study demonstrate that adult children perceive aging parents as insisting, persisting, or resisting in ways or opinion (i.e., acting in a way commonly attributed to stubbornness) fairly often. Furthermore, aging parents also self-perceive themselves as acting in this way. And, perceptions of parents and children are linked to a series of individual and relationship-based factors. However, there are differential characteristics related to children’s perceptions as compared to parents’ and there are systematic discrepancies in perceived parent stubbornness between parents’ self-reports and adult child reports.

These findings carry several implications for research and practice. First, as hypothesized, older adults are perceived as resisting, insisting, or persisting in their ways or opinion, i.e., acting in a way commonly attributed to stubbornness, by both adult children and aging parents. While it is unclear how the perceptions of these behaviors correspond directly with actual objective behaviors, the frequency with which perceptions are reported implicates that such behaviors are occurring. This finding indicates that families are encountering conflicts in care or relationship-based goals that result in resistant responses by parents. There is room for conversation around goals and a possible need to set expectations that are amenable to both family members. The fact that parents are self-aware may mean there is a greater opportunity to discuss goal differences, as on some level parents are knowingly acting in this “resistive” manner. The behaviors may be an expression of independence by parents to try to do as much
for themselves as possible. Or it may be a form of exercising personal control, as both autonomy and control are vital for continued development into old age (Deci & Ryan, 2000). However, there may be a disconnect between children and parents on understanding the importance of this goal that could be resolved through improved communication.

Second, the findings here illustrate that the perceptions of aging parents and their adult children regarding the frequency of parents’ stubbornness are differentially related to a series of individual and relationship-based characteristics. While we cannot confirm the causal directionality of effects, we see that reports of parents’ perceived stubbornness by children are related to parent disability, parent gender, parent neuroticism, children’s use of avoidant coping responses in times of relationship conflict, and children’s experience of stress in helping their parents. Additionally parents’ self-reports are related to higher levels of parents’ own education, lower levels of their child’s education, and the support parents report providing to their adult children. Of note, the perceptions of behaviors are not driven by or associated solely with parent-based characteristics. Rather, we find that as hypothesized they are imbedded in the larger context of relationship functioning. In other words, when there are goal conflicts, parent, child, and relationship-based characteristics affect how the relationship is functioning.

In particular, consistent with theories of disability (Verbrugge & Jette, 1994), control (Heckhausen & Schulz, 1995), and dependency (M. Baltes 1995; 1996), we see that children perceive more stubbornness when parents have greater disability. And, similarly, better parent health is correlated with less perceived stubbornness. As a child perceives that his/her parent lacks the physical ability to accomplish a goal, he/she perceives a parent as acting in a way commonly attributed to stubbornness. However, when parents have less disability there are fewer situations where they insist on doing things for themselves that children view as
problematic. In other words, there are fewer situations leading to goal conflict and perceptions of stubbornness. Conversely, the association of goal conflict and disability may reflect that older adults are still trying to maintain self-direction in the face of limitations by relying on primary control (i.e., direct action on their environment) when a more adaptive approach of secondary or collaborative control (i.e., cognitive appraisals or support from others; Heckhausen & Schulz, 1995; Krause, 2003) would be more useful. Encouraging parents to utilize a strategy such as selection, optimization, with compensation, for example, may augment their ability to continue to act on their environments in areas that are most important to them, while simultaneously allowing support in other tasks (Freund & P. Baltes, 1998). A shift in behaviors in this manner may then reduce the occurrence of goal conflicts that result in elders being perceived as resistive.

Another implication of this finding is that with increased disability, children may see safety as something of higher importance or concern (Kane, 1995), yet parents may not share this same anxiety, but rather be focused on doing as much as they can still do for themselves. Children may see their parents as trying to act in a way that is contrary to their own goal of safety, and thereby make the attribution that their parents are acting in a way that is disregarding possible negative outcomes. Further investigation is needed, however, to parse out the limitations of parents and whether their behaviors are in fact adaptive or maladaptive in regard to negative outcomes and to determine how adult children caring for older parents with disability can best respond to such changes. It may be that when families are faced with greater parental disability there is a need to address care/relationship goals more readily to set adaptive goals for parents that allow them to continue to act on their environment as much as they can (i.e., through selection-optimization-compensation strategies, secondary control, or collaborative control; Freund & P. Baltes, 1998; Heckhausen & Schulz, 1995; Krause, 2003). Or, it may be pertinent
to address the misperceptions of children who misjudge their parents as incapable when parents have increased physical limitation for activities when their parent is in fact not lacking competence. Such discussion may allow for better understanding of each person’s needs, goals, and abilities and decrease any tension brought on by conflicting goals, ultimately improving well-being and relationship quality. In fact, findings support the possible benefit of reducing these occurrences of goal conflict, as higher levels of relationship quality were correlated with lower frequencies of child reported perceived parent stubbornness.

Beyond disability, individual-level characteristics were also found to be associated with the occurrence of persistent behaviors, or behaviors commonly attributed to stubbornness, by parents. Parent neuroticism and parent gender were found to be associated with children’s reports of parent behaviors that are commonly attributed to stubbornness. And, the individual characteristics of parent’s level of education and children’s education were associated with parents’ self-reports of “stubbornness”. Such associations may indicate that there are predisposing factors within individuals that influence the experience or perception of parental stubbornness. Families exhibiting these characteristics may be challenged more with navigating such conflicts. More specifically it was hypothesized that less agreeableness would result in higher perceptions of parent stubbornness, yet instead it appears that the qualities of neuroticism are what matter. Neuroticism has been linked to hostility and self-consciousness and lower well-being (Costa, McCrae, & Norris, 1981); thus, it is plausible that higher levels of these negative attributes of neuroticism in a parent contributes to the development of conflict in relationship goals as studied here. It may also be that older people higher in neuroticism are also less flexible in adjusting goals in relation to changes in the environment or their own abilities. Regarding child reports of parent stubbornness, the additional effects around fathers versus mothers may
reflect a differential response of children to their parents, perhaps seeing their fathers’ actions as less moveable or adaptable. Older men could be displaying more behaviors commonly attributed to stubbornness in an attempt to maintain independence given the meaning they derive from work and functioning (Granville & Evandrou, 2010). Meanwhile, parents with higher education are more likely to report stubbornness, which could reflect that they are more likely to believe that their own goals are best and to persist in the face of challenges, as education has been previously linked to sense of control (Slagsvold & Sørensen, 2008). In contrast, children with less education may be less understanding or perceptive of parents’ needs/goals from the parents’ perspective, which results in the parent seeing him/herself as displaying such responses to conflict in goals more often. Further investigation around these findings concerning education in particular would be interesting to determine if it is truly education in and of itself as interpreted here that results in more stubbornness or if education proxies for some other construct not accounted for in this study.

Beyond individual characteristics, perceptions of parents’ behaviors by adult children and aging parents are also linked to what is going on in the relationship. While factors such as gender, neuroticism, and disability are arguably immovable, findings here demonstrate that how the parent and child are interacting in other ways may influence the exposure to situations of goal differences where an older adult persists in his/her ways or opinions. For example, when children report more generally avoiding conflict they also report more stubbornness by their parents. The use of avoidance as an “exit strategy” has been documented as a response to relationship tensions (Birditt & Fingerman, 2005). Thus, it may be that the use of this strategy as a coping response increases when stubbornness is present. Or vice versa, avoiding conflict may lead to more persistence by the aging parent, or the perception of such by children. It is possible
that children who use avoidant coping behaviors are not taking the time to find more adaptive strategies to effectively communicate with their parents to resolve goal differences. Additionally children who report more stress when helping their parent report more perceived stubbornness by their parent. Again, it may be that such behaviors cause more stress or that the stress causes more behaviors by the parent. However, it is likely that the stubbornness responses by parents brought on by differing goals also result in children’s perception of stress. The very act of hoping a parent will pursue a goal that offspring believe is eminently reasonable and then perceiving their parent as resisting it is likely stressful. For, past research has shown that tensions in parent-child relationships contribute to daily stress exposure (Birditt, Cichy, & Almeida, 2011). Additionally, regarding parent self-reports of stubbornness, we found that more support given to a child by a parent is linked to more parent self-reported stubbornness. This finding is contrary to the hypothesized pathway but may reflect the fact that when the parent is interacting with their child to give support they are also encountering more goal conflict than those parents that are not giving their children as much support. Or it could be that the provision of support, or actions associated with giving such support, in some way results in more persistence or insistence by a parent.

On the whole, the effects of relationship factors on the outcome of parent behaviors highlight the complexity of relationships and how one relationship process can have an impact on another. It may be that by clinically addressing parents’ behaviors commonly attributed to stubbornness in some way, other relationship characteristics will change (i.e., stress, avoidant coping, or support provided), given the interrelated nature of human functioning (Ford, 1994). Or, it may be that by decreasing relationship concerns, such as stress experienced when helping a parent or the use of avoidant coping strategies when there is conflict, the occurrence of situations
where parents are seen as acting in a way commonly attributed to stubbornness may also decrease. Ultimately, there is room for intervention and change. Families may benefit from clinical support directed at helping them navigate times of increased parent disability, in particular, by learning how to better communicate their needs and goals to one another.

Furthermore, despite the self-awareness by parents of their stubbornness, there is discordance in understanding between adult children and their parents about how frequently parents display such behaviors. Children report higher levels of parent stubbornness than parents self-report. Such discordance in perceptions around goals and values is consistent with other findings in the literature (Carpenter et al., 2000; Fagerlin et al., 2002; McCullough et al., 1993; Reamy et al., 2011; Uhlmann et al., 1988; Whitlatch & Feinberg, 2003). This discrepancy is also associated with individual and relationship-based characteristics of parents and adult children. As with child reports, discrepancy is greater when there is more parent disability. It could be that the child sees an aging parent as declining in ability and therefore becomes hyper-attuned to safety needs and the acts of a parent that could lead to potential negative outcomes. Or, children are likely or will likely be sliding into roles with more power for decision making (Pyke, 1999) and may feel more responsible for their parents’ actions and want to encourage their parents’ best interests. Therefore, children see their parents as pushing limits more or may impose their own preferences on their parents more often. Meanwhile parents may be reporting less frequency of goal conflict, as they feel more in tune with their own abilities—maintaining confidence in their actions and not seeing themselves as insisting or persisting. Additionally, higher reported relationship quality and support a parent gives to a child are linked to the parent self-reporting more behaviors than children. Thus, when children do not over classify parent behaviors as persistent or insistent they see their relationships with their parents as functioning
better and their parents report providing more support to them. Meanwhile, those children that
avoid conflict in general also over-report more. These findings implicate that there may be a
benefit to the child having a better understanding of parents’ rationale for acting persistently to
decrease over-reporting. Dyadic interventions that address each person’s relationship and/or
support-based goals (e.g., Whitlatch, Judge, Zarit, & Femia, 2006) may increase understanding
about each other’s perspectives when providing general support to each other. Further, such
findings and intervention implications may be particularly important for father-child
relationships, as the discrepancy is higher for fathers than mothers.

Additionally of interest, ‘stubborn personality’ and the frequency of parents’ self-reports
of stubbornness are correlated, which confirms that we are tapping into similar phenomenon.
Those parents who call themselves “stubborn” are also endorsing behaviors commonly attributed
to stubbornness. However, the findings of this study reveal that the frequency of behaviors
commonly attributed to stubbornness and parents’ self-endorsed ‘stubborn personality’ are
correlated at a fairly low level (0.22, p < .05). Furthermore, one’s ‘stubborn’ personality is not a
significant predictor in regressions of parent behaviors commonly attributed to stubbornness.
Thus, there is a need to examine personality as distinct from behaviors. Calling someone a
stubborn person appears distinct from displaying behaviors that are commonly attributed to
stubbornness.

Overall, the results presented here are strengthened by the novelty of this investigation of
older parents’ behaviors of insisting and resisting, i.e., behaviors commonly attributed to
stubbornness, which have not been studied prior. They are further strengthened by the use of
dyadic data of both family members reporting on the same constructs. However, they are not
without limitation. Though the initial sample was drawn from a randomized probability sample
of individuals, the small subset of individuals used for these analyses were unique in that they were willing to participate in a longitudinal investigation regarding support exchanges within their families, they represent families with a middle aged adult who has a parent still living, and they represent families where both the middle-aged child and a parent were willing to participate in the study. As a result, the generalizability of the findings is limited and results should be considered exploratory. This study is an initial effort at describing how these behaviors present in families. Secondly, there were only a small number of cases where both parents were alive and participated in the study \((n = 11)\). As a result, we could not use these reports. With more cases with this type of dependent data within families, multi-level models of estimation could be utilized to examine between and within family differences in associations with the outcome variables. Third, we took a parsimonious strategy in building models; however, the size of the sample may have limited the power to detect additional relationships among variables measured. A larger sample would allow for better testing of variables of interest. Fourth, the attributions of behaviors tested here were generated from a pilot study with middle-aged adults, but additional behaviors may also exist that are commonly attributed to stubbornness. Inclusion of an open-ended question would allow for further examination of possible missed constructs that could be more salient. Last, the relationships discussed here are retrospective and ask about general behaviors at one point in time. More could be learned from studying such patterns of behaviors over time and in specific situational contexts.

In the end, findings suggest that middle-aged adults and their aging parents do perceive parents as acting in ways that are commonly attributed to stubbornness. Adult children and their parents perceive such responses to conflicts in care or relationship-based goals whereby a parent insists, persists, or resists differently. Children perceive higher levels of such parental behaviors
than parents self-report. These behaviors are also situated within the larger context of individual-based and relationship-based characteristics and functioning. Individual characteristics may act as predisposing factors whereby families experience such responses by parents to conflicts in goals more readily. Additionally, behaviors are linked to relationship-based processes that may be amenable to change. Overall, such presence of and differential perspectives around behaviors of parents carry implications for interventions to support families that are providing care and support to their older loved ones. However, future work is needed to tease out the actual effects of stubbornness on individual and relationship functioning and to determine how responses to such behaviors impact care and support. Furthermore, work is needed to delineate what forms of support and/or intervention strategies would be most useful to families encountering such responses to goal conflict to ultimately achieve a balance between older adults’ and their adult children’s needs and goals. Meanwhile, practical work can be informed by these preliminary findings that demonstrate the occurrence of behaviors commonly attributed to stubbornness in parent-adult child relationships and a possible need for improved communication around goals within families. Given the relationships found here, particularly in regard to parent disability, it may be that by addressing such behaviors and interactions within families the future burden experienced by many families in providing care and support to their older loved ones will be decreased and care-based outcomes for elders will be improved.
Table 4.1

**Hypothesized regression relationships and actual relationships of proposed variables with perceptions of parents’ behaviors attributed to stubbornness by adult children, aging parents, and their discrepancy in perspectives**

<table>
<thead>
<tr>
<th>Child Characteristics:</th>
<th><strong>HYPOTHESED</strong></th>
<th><strong>ACTUAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Age</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Education</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Gender</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Income</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Physical Health</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Geographic Distance</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Avoidant Coping Responses</td>
<td>+</td>
<td>…</td>
</tr>
<tr>
<td>Solidarity beliefs about helping</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Contingency Beliefs about helping</td>
<td>+</td>
<td>…</td>
</tr>
<tr>
<td>Feelings of Obligation</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Stressfulness of helping parent</td>
<td>+</td>
<td>…</td>
</tr>
<tr>
<td>Support Provided</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

**Parent Characteristics:**

<table>
<thead>
<tr>
<th></th>
<th><strong>HYPOTHESED</strong></th>
<th><strong>ACTUAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child</td>
<td>Parent</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Age</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Education</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Gender</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Income</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Physical Health</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Stubborn Personality</td>
<td>…</td>
<td>+</td>
</tr>
<tr>
<td>Parent Disability (report by Child)</td>
<td>+</td>
<td>…</td>
</tr>
<tr>
<td>Support Provided</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

*Note:* – represents a negative relationship, + represents a positive relationship, … represents no relationship predicted or no relationship found.
Table 4.2

Variables examined in relation to parent and adult child reports of parent stubbornness

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>WHOSE REPORTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADULT CHILD</td>
<td>PARENT</td>
</tr>
<tr>
<td><strong>Demographic Variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Education</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Gender</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Income</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Physical Health</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Geographic Distance</td>
<td>X</td>
<td>----</td>
</tr>
<tr>
<td><strong>Relationship Variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>“Stubborn” personality</td>
<td>----</td>
<td>x</td>
</tr>
<tr>
<td>Current Disability</td>
<td>----</td>
<td>x</td>
</tr>
<tr>
<td>(reported by children about parents)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidant Coping Behaviors</td>
<td>x</td>
<td>----</td>
</tr>
<tr>
<td>Solidarity Beliefs</td>
<td>x</td>
<td>----</td>
</tr>
<tr>
<td>Contingency Beliefs</td>
<td>x</td>
<td>----</td>
</tr>
<tr>
<td>Obligation to Help</td>
<td>x</td>
<td>----</td>
</tr>
<tr>
<td>Stressfulness of Providing Help</td>
<td>x</td>
<td>----</td>
</tr>
<tr>
<td>Support Provided</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>Outcome Variable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Stubbornness</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Table 4.3
Correlations of individual and relationship-based characteristics with middle-aged adults’ reports and parents’ self-reports of parents’ stubbornness

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OVERALL (n = 88)</td>
<td>MOTHERS (n = 64)</td>
<td>FATHERS (n = 24)</td>
</tr>
<tr>
<td></td>
<td>MOTHERS (n = 64)</td>
<td>FATHERS (n = 24)</td>
<td>MOTHERS (n = 64)</td>
</tr>
<tr>
<td><strong>Child Variables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-.13</td>
<td>-.06</td>
<td>-.29</td>
</tr>
<tr>
<td>Age</td>
<td>-.10</td>
<td>-.08</td>
<td>-.07</td>
</tr>
<tr>
<td>Education</td>
<td>-.04</td>
<td>.14</td>
<td>-.27</td>
</tr>
<tr>
<td>Gender</td>
<td>-.15</td>
<td>-.23†</td>
<td>.12</td>
</tr>
<tr>
<td>Income</td>
<td>.09</td>
<td>.09</td>
<td>.11</td>
</tr>
<tr>
<td>Physical Health</td>
<td>.02</td>
<td>-.10</td>
<td>.23</td>
</tr>
<tr>
<td>Geographic Distance</td>
<td>-.001</td>
<td>-.04</td>
<td>.19</td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>-.40***</td>
<td>-.42***</td>
<td>-.50**</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>.23†</td>
<td>.21</td>
<td>.23</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.08</td>
<td>.09</td>
<td>-.13</td>
</tr>
<tr>
<td>Avoiding Coping</td>
<td>.31**</td>
<td>.26**</td>
<td>.53**</td>
</tr>
<tr>
<td>Solidarity Beliefs</td>
<td>.09</td>
<td>.02</td>
<td>.30</td>
</tr>
<tr>
<td>Contingency Beliefs</td>
<td>.28**</td>
<td>.22**</td>
<td>.21</td>
</tr>
<tr>
<td>Obligation to Help</td>
<td>.09</td>
<td>-.17</td>
<td>.14</td>
</tr>
<tr>
<td>Stressfulness of Providing help</td>
<td>.47***</td>
<td>.51***</td>
<td>.49*</td>
</tr>
<tr>
<td>Support Provided</td>
<td>.11</td>
<td>.19</td>
<td>.07</td>
</tr>
<tr>
<td><strong>Parent Variables:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-.11</td>
<td>-.03</td>
<td>-.29</td>
</tr>
<tr>
<td>Age</td>
<td>.10</td>
<td>.09</td>
<td>.12</td>
</tr>
<tr>
<td>Education</td>
<td>-.01</td>
<td>.12</td>
<td>-.24</td>
</tr>
<tr>
<td>Gender</td>
<td>.24†</td>
<td>.09</td>
<td>.24</td>
</tr>
<tr>
<td>Income</td>
<td>-.15</td>
<td>-.23†</td>
<td>.05</td>
</tr>
<tr>
<td>Physical Health</td>
<td>-.28**</td>
<td>-.37**</td>
<td>-.02</td>
</tr>
<tr>
<td>Relationship Quality</td>
<td>-.39***</td>
<td>-.37**</td>
<td>-.40†</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>.26†</td>
<td>.32*</td>
<td>.41*</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>-.16</td>
<td>-.10</td>
<td>-.05</td>
</tr>
<tr>
<td>Stubborn Personality</td>
<td>.14</td>
<td>.11</td>
<td>.17</td>
</tr>
<tr>
<td>Current disability</td>
<td>.04***</td>
<td>.49***</td>
<td>.41*</td>
</tr>
<tr>
<td>Support Provided</td>
<td>.01</td>
<td>.001</td>
<td>.07</td>
</tr>
</tbody>
</table>

Note. N = 88 families. †p < .10. *p < .05. **p < .01. ***p < .001. Means and standard deviations are for the full sample, not broken out by Parent (mother/father).
Table 4.4

Demographic, individual, and relationship-based characteristics entered into analyses

<table>
<thead>
<tr>
<th>OUTCOME 1: Child reports of Parent Stubbornness</th>
<th>OUTCOME 2: Parent report of own stubbornness</th>
<th>OUTCOME 3: Discrepancy in reports of parent stubbornness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1: ACCOUNTING FOR DEMOGRAPHIC CHARACTERISTICS OF THE REPORTER IN THE MODEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILD GENDER†</td>
<td>PARENT RACE/ETHNICITY†</td>
<td>PARENT GENDER</td>
</tr>
<tr>
<td></td>
<td>PARENT EDUCATION†</td>
<td>PARENT EDUCATION</td>
</tr>
<tr>
<td></td>
<td>PARENT PHYSICAL HEALTH</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 2: ACCOUNTING FOR DEMOGRAPHIC CHARACTERISTICS OF THE PARTNER IN THE MODEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARENT GENDER</td>
<td>CHILD EDUCATION</td>
<td></td>
</tr>
<tr>
<td>PARENT INCOME†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARENT PHYSICAL HEALTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 3: ACCOUNTING FOR OWN REPORTS OF INDIVIDUAL AND RELATIONSHIP-BASED CHARACTERISTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILD PERCEIVED RELATIONSHIP QUALITY</td>
<td>PARENT NEUROTICISM†</td>
<td>PARENT PERCEIVED RELATIONSHIP QUALITY</td>
</tr>
<tr>
<td>CHILD NEUROTICISM</td>
<td>PARENT STUBBORN PERSONALITY</td>
<td>PARENT CURRENT DISABILITY</td>
</tr>
<tr>
<td>CHILD AVOIDANT COPING BEHAVIORS IN RESPONSE TO RELATIONSHIP PROBLEMS</td>
<td>PARENT REPORTED SUPPORT PROVIDED TO CHILD</td>
<td>PARENT REPORTED SUPPORT PROVIDED TO CHILD</td>
</tr>
<tr>
<td>CHILD CONTINGENCY BELIEFS ABOUT HELPING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILD STRESSFULNESS OF HELPING PARENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 4: ACCOUNTING FOR PARTNER REPORTS OF INDIVIDUAL AND RELATIONSHIP-BASED CHARACTERISTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARENT PERCEIVED RELATIONSHIP QUALITY</td>
<td>CHILD SOLIDARITY BELIEFS ABOUT HELPING</td>
<td>CHILD PERCEIVED RELATIONSHIP QUALITY</td>
</tr>
<tr>
<td>PARENT NEUROTICISM</td>
<td></td>
<td>CHILD AVOIDANT COPING BEHAVIORS IN RESPONSE TO RELATIONSHIP PROBLEMS</td>
</tr>
<tr>
<td>PARENT CURRENT DISABILITY</td>
<td></td>
<td>CHILD SOLIDARITY BELIEFS ABOUT HELPING†</td>
</tr>
</tbody>
</table>

*Note. Only variables that showed at least a statistical trend in correlation with the specified outcome variable were tested ($p < .10$). †Variables only trending.*
### Table 4.5

**Descriptives of parent stubbornness items rated by middle-aged adult children and their parents**

<table>
<thead>
<tr>
<th>Item (“To what extent does your mother/father ever...”)</th>
<th>Child’s Perception of Parent Stubbornness</th>
<th>Parent’s Perception of Own Stubbornness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child’s Perceptions of Parent Stubbornness</td>
<td>Parent’s Perceptions of Own Stubbornness</td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
<td>Range</td>
</tr>
<tr>
<td>… ignore suggestions or advice from you that would make his life better, safer, or easier?</td>
<td>1.73 (1.05)</td>
<td>0 to 4</td>
</tr>
<tr>
<td>… ignore or refuse to do what his doctor tells him to do?</td>
<td>1.28 (1.02)</td>
<td>0 to 4</td>
</tr>
<tr>
<td>… insist on doing things his own way even if it makes his life more difficult or unsafe?</td>
<td>2.11 (1.08)</td>
<td>0 to 4</td>
</tr>
<tr>
<td>… insist on doing things his own way even if it makes someone else’s life more difficult, inconvenienced, or unsafe?</td>
<td>1.67 (1.08)</td>
<td>0 to 4</td>
</tr>
<tr>
<td>Starkness Scale</td>
<td>6.67 (3.45)</td>
<td>0 to 15</td>
</tr>
</tbody>
</table>

*Note.* N = 88 dyads; 64 mothers, 24 fathers. *Skewness and Kurtosis are estimated from the full overall sample, not by Parent (Mother/Father).*
Table 4.6

Effect of individual and relationship-based characteristics on child-reported parent stubbornness

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th></th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
<td>β</td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
<td>β</td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
<td>β</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>8.55***</td>
<td>0.97</td>
<td>--</td>
<td>3.21*</td>
<td>1.36</td>
<td>--</td>
<td>-1.15</td>
<td>1.90</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Gender (F=0, M=1)</td>
<td>1.48†</td>
<td>0.78</td>
<td>0.20</td>
<td>1.85**</td>
<td>0.67</td>
<td>0.25</td>
<td>2.50***</td>
<td>0.67</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Health</td>
<td>-0.80*</td>
<td>0.30</td>
<td>-0.27</td>
<td>-0.54*</td>
<td>0.27</td>
<td>-0.18</td>
<td>-0.03</td>
<td>0.28</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Avoidant Coping</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1.00*</td>
<td>0.46</td>
<td>0.20</td>
<td>0.86*</td>
<td>0.43</td>
<td>0.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Stress of Helping</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1.22***</td>
<td>0.27</td>
<td>0.42</td>
<td>0.86**</td>
<td>0.28</td>
<td>0.29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Neuroticism</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1.20*</td>
<td>0.48</td>
<td>0.24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Disability</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.89**</td>
<td>0.28</td>
<td>0.32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R<sup>2</sup>  | 0.11      | 0.36      | 0.45      |
Δ R<sup>2</sup> | --        | 0.24      | 0.10      |
F               | 5.34**    | 11.19***  | 10.88***  |

**Note.** †p < .10, *p < .05, **p < .01, ***p < .001. Models were run on N = 88 dyads of middle-aged adults and aging parents who had complete data on all variables of interest. Child demographics were also tried in the model, but were all non-significant (p > .10) and were dropped from the model. Additional variables at each of the remaining steps were trimmed along the way when not significant, to result in the final model presented here.
Table 4.7

Effect of individual and relationship-based characteristics on parent self-reported stubbornness

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
<td>β</td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
<td>β</td>
<td>B</td>
<td>SE&lt;sub&gt;B&lt;/sub&gt;</td>
</tr>
<tr>
<td>Intercept</td>
<td>4.40***</td>
<td>0.99</td>
<td>--</td>
<td>5.55***</td>
<td>1.07</td>
<td>--</td>
<td>3.11†</td>
<td>1.59</td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Education</td>
<td>0.49†</td>
<td>0.26</td>
<td>0.20</td>
<td>0.73**</td>
<td>0.27</td>
<td>0.29</td>
<td>0.73**</td>
<td>0.26</td>
</tr>
<tr>
<td>Parent Health</td>
<td>-0.59*</td>
<td>0.23</td>
<td>-0.27</td>
<td>-0.48*</td>
<td>0.22</td>
<td>-0.22</td>
<td>-0.37†</td>
<td>0.23</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Education</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>-0.60*</td>
<td>0.24</td>
<td>-0.28</td>
<td>-0.49*</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent reported Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provided to Child</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.45*</td>
<td>0.22</td>
</tr>
</tbody>
</table>

R<sup>2</sup> 0.11 0.17 0.21
Δ R<sup>2</sup> 0.06 0.04
F 5.08** 5.71*** 5.50***

Note. †p < .10. *p < .05. **p < .01. ***p < .001. Models were run on N = 88 dyads of middle-aged adults and aging parents who had complete data on all variables of interest. Child characteristics were also tried in the model, but were all non-significant (p > .10) and were dropped from the model. Additional variables at each of the remaining steps were trimmed along the way when not significant, to result in the final model presented here.
### Table 4.8

*The association of individual and relationship-based characteristics with discrepancy in reports of parents’ stubbornness*

<table>
<thead>
<tr>
<th></th>
<th>MODEL 1</th>
<th>MODEL 2</th>
<th>MODEL 3</th>
<th>MODEL 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$</td>
<td>$B$</td>
<td>$SE$</td>
</tr>
<tr>
<td><strong>Fixed effect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept (mean)</td>
<td>5.28***</td>
<td>0.25</td>
<td>5.10***</td>
<td>0.29</td>
</tr>
<tr>
<td>Slope (discrepancy)*</td>
<td>2.75***</td>
<td>0.41</td>
<td>2.11***</td>
<td>0.46</td>
</tr>
<tr>
<td><strong>Predictors of mean</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parent Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Gender ($1 = Male, 0 = Female$)</td>
<td>--</td>
<td>--</td>
<td>0.67</td>
<td>0.56</td>
</tr>
<tr>
<td>Parent-reported Relationship Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Parent Current Disability</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Parent-reported Support Provided to Child</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Child Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child-reported Relationship Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Avoidant Coping Response</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Stress in Helping Parent</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Predictors of discrepancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parent Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Gender ($1 = Male, 0 = Female$)</td>
<td>--</td>
<td>--</td>
<td>2.35**</td>
<td>0.88</td>
</tr>
<tr>
<td>Parent-reported Relationship Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Parent Current Disability</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Parent-reported Support Provided to Child</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Child Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child-reported Relationship Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Avoidant Coping Response</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Stress in Helping Parent</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Random effect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variance (mean)</td>
<td>1.92*</td>
<td>1.00</td>
<td>2.13*</td>
<td>0.99</td>
</tr>
<tr>
<td>Residual</td>
<td>7.23***</td>
<td>1.10</td>
<td>6.76***</td>
<td>1.03</td>
</tr>
<tr>
<td>-2 Log Likelihood</td>
<td>884.1</td>
<td>873.5</td>
<td>831.3</td>
<td>835.3</td>
</tr>
<tr>
<td>AIC</td>
<td>888.1</td>
<td>877.5</td>
<td>835.3</td>
<td>792.3</td>
</tr>
</tbody>
</table>

*Note.* Dyad $N = 88$. †$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$. *Negative coefficients indicate that the parent is self-reporting more stubbornness than the adult child is reporting; Positive coefficients indicate that the adult child is reporting more stubbornness than their parent is self-reporting.
Figure 4.1

*Hypothesized process of appraisal of parent’s behavior by child as “stubbornness”*
Hypothesized association of perceived parent behaviors attributed to stubbornness with other variables
Chapter 5. Study 3—The Consequences of Adult Children’s Responses to Parent “Stubbornness”

5.1 Abstract

Relationship tensions have been shown to evoke a number of unique response patterns from individuals. However, in the context of providing care or support to older adults, the responses to a particular form of conflict whereby older adults insist, resist, or persist in their ways or opinion, or act in a way that is commonly attributed to stubbornness, have not been addressed. Such behavioral episodes by elders in relationships with their adult children may result in unique patterns of responses that affect relationship and individual-based outcomes. With a sample of 221 middle-aged adults who were telephone interviewed as a component of a larger multi-stage survey study, we examined the prevalence of children’s behavioral response patterns to parents’ behaviors that are commonly attributed to stubbornness. Utilizing multiple regression and multi-level models we explored the relationship of response strategies with depressive symptoms, relationship quality, and forms of support provided by adult children to their parents. Overall, we found that middle-aged adults endorse most frequently responding to elders’ behaviors to persist, insist, or resist by just letting their requests go. Additionally, after controlling for frequency of perceived stubbornness by parents, differential response strategies by adult children were associated with adult children’s reports of depressive symptoms (getting upset, waiting to ask again another day, letting their request go, and reasoning), their perception of relationship quality (arguing, rewording their request, and letting their request go), the amount of support they provide to a parent (arguing and reasoning), and the endorsement of providing caregiving support to a parent (letting their request go and arguing). Such findings demonstrate that beyond middle-aged adults’ perceptions of parents acting in ways commonly attributed to stubbornness how they respond to elders’ behaviors can affect individual and relationship outcomes, as well as the care or support they provide to their aging parents. Interventions to address such response strategies may prove particularly useful in helping families mitigate the negative effects of particular response styles.
The Consequences of Adult Children’s Responses to Parent “Stubbornness”

5.2 Background & Significance

As individuals age, they often experience declines in biological ability and in their ability to use and rely on cultural resources (P. Baltes, 1997). They encounter an increasing need for cultural and social supports to maintain successful levels of functioning (P. Baltes, Freund, & Li, 2005). Most often elders will turn to the support of family and friends, and shift their physical efforts away from primary attempts of control on their environment to more secondary control mechanisms (i.e., change in perceptions or responses to a goal; Heckhausen & Schulz, 1995) to maintain a sense of self-direction in life. Yet, given the continued need to experience autonomy and control in their lives (Deci & Ryan, 2000), elders must learn to balance their dependency on others within the context of their own abilities and competence (M. Baltes, 1995; 1996). Oftentimes those who learn to adapt to such changes by focusing their efforts through selection, optimizing their performance in that selected activity, and compensating in other challenging areas, will continue to age ‘successfully’ (i.e., higher levels of well-being and functioning; Freund & P. Baltes, 1998). Such forms of compensation may include the use of more collaborative control efforts (i.e., jointly acting in response to a stressor; Krause, 2003) or forms of dyadic coping in times of stress, illness, or disability (Berg & Upchurch, 2007).

However, regardless of the exact tasks or the magnitude of support needed, relying on others can become complicated due to the inherent complexity of social relationships. When multiple people are involved in navigating the daily lives and care of an elder, differences in opinions and conflict are likely to ensue. Individuals are complex human systems, each with his/her own personal goals (Ford, 1994). As a result, goals of two people may not always match.
Such a mismatch of goals between an older person and relative or care provider may affect provision of support and lead to negative (hostile, ambivalent, or superficial coping) or delegated (one person takes responsibility) coping responses within dyads (Lederman et al., 2010).

Elders and their adult children, in particular, may experience differences in perspectives given the reversal of roles whereby the parent is no longer as able to directly act on his or her environment and the child obtains the power to do so for the parent (Birditt, Miller, Fingerman, & Lefkowitz, 2009; Fingerman, 1996; Pyke, 1999). Unique tensions between mothers and daughters have been documented (Fingerman, 1996) as well as the fact that adult children tend to gradually take over in day-to-day decision making (McGraw & Walker, 2004). In such instances, children’s efforts to act in their parents’ best interests may challenge elders’ own goals and preferences, resulting in a building of relationship tension (Birditt, Miller et al., 2009). As tension builds and one person sends a message to define the relationship, another has to respond and accept or reject the definition (Haley, 1963). If the elder rejects the proposed relationship definition or a requested behavior or goal of the child, he or she may act, or be seen as acting, resistively. This response of an elder insisting, persisting or resisting in response to goal conflict is of particular interest, as it likely evokes a pattern of response behaviors from his/her adult child that carry implications for relationship quality or individual well-being, as well as how care and support is provided. However, such behaviors of and responses to elders’ insisting, resisting, or persisting behaviors are not well understood.

Persistence in the face of conflicting goals would be expected to evoke a variety of responses, as individuals are thought to cope in a diversity of ways to stress and conflict in their lives (i.e., Folkman, Lazarus, Pimley, & Novacek, 1987). Children may respond directly or actively to their parents’ behaviors or more indirectly or passively, as found in the relationship
tension literature (Birditt, Cichy, & Almeida, 2011). How a family member responds to the conflict may then be linked to relationship outcomes such as affective solidarity and ambivalence (Birditt, Rott, & Fingerman, 2009). In specific, employing passive avoidance or active destructive response strategies is linked to decreased solidarity and increased ambivalence, suggesting that the responses elicited from a family member by an elder in instances of goal conflict may also carry negative implications (Birditt, Rott et al., 2009). Additionally, conflict in relationships may also be linked to provision of support either in a general sense or when caregiving is needed (Merz, Consedine, Schulze, & Schuengel, 2009; Schwarz, Trommsdorff, Albert, & Mayer, 2005). Further understanding of such processes in relationships where a relative provides care or support to an elder is needed. An understanding of the dynamics of goal pursuit may teach us how to maximize parents’ and children’s well-being and functioning when aging parents are in need of social support.

More specifically, behaviors of insistence, persistence, and resistance are commonly attributed to stubbornness. “Stubbornness” as a construct has been linked to greater bargaining power or a reputation that can enhance bargaining power in decision-making in general (Kambe, 1999). Yet for elders, such persistence in goal striving has been shown to be less effective in relation to well-being outcomes as compared to younger adults (Wrosch, Heckhausen, & Lachman, 2000). It has also been linked qualitatively to suicide when an individual’s self-esteem is strongly associated with being productive and in control (Kjølseth, Ekeberg & Steihaug, 2009) and to other negative characteristics such as strong will, poor health, loneliness, reduced zest for life, depressive symptoms, lack of activities, and an uncertain future (Kulla, Sarvimäki, & Fagerström, 2006). These findings may in part be related to the effect others’ responses have on an individual when they see that individual as acting “stubborn”. However, in
work reviewed, a single item or single descriptor of “stubborn” has been employed to measure this construct (Allen, 1999; Berdie, 1940; Buchanan & Holmbeck, 1998; Caspi, Roberts, & Shiner 2005; Chen, 2010; Davey, Eaker, & Walters, 2003; Demiris et al., 2008; Dong et al., 2011; Holland & Roisman, 2008; Jensen-Campbell & Graziano, 2001; McCrae & Costa, 1987; 1992; Metfessel & Lovell, 1942; Ramirez, 2010; Robinson, 2008; Skovdahl, Larsson Kihlgren, & Kihlgren, 2004; Stull, Cosbey, Bowman, & McNutt, 1997). The measurement of stubbornness as a form of behavioral interaction whereby an elder meets resistance and pushes, persists, or insists on acting a specified way despite possible outcomes are not addressed. Furthermore the responses by others to such behaviors commonly attributed to stubbornness have not been explored. Thus, there is a need to further understand elders’ resisting and insisting behaviors commonly attributed to stubbornness and more specifically the responses they evoke from others around them and the consequences of such responses on the relationship.

Within the family context such work has implications for interventions that address perceptions and goals in relationships. If frustrating sequences of goal conflict take place within adult child-parent relationships and responses to such behaviors result in negative outcomes, interventions may be able to take a problem-solving approach to decreasing conflict. Theoretical work discusses the strengths of intervening at the level of the relationship to bring about positive developmental changes (i.e., Berg & Upchurch, 2007; Haley 1963; McGilton, 2002; Shellenberger, Watkins, & Drake, 1989). Furthermore, dyadic-based interventions can improve quality of life, family communication (Logsdon et al., 2010), and mental health (Martire, Lustig, Schulz, Miller, & Helgeson, 2004). Ultimately, if the responses of adult children to behaviors perceived as stubbornness are also linked to negative individual or relationship-based outcomes or to decreased support provided then such interventions around communication and goals may
prove vital in supporting families.

As a result, to address the dearth of research on this topic, this study sought to answer the following questions:

1. How do adult children respond to their parents’ behaviors to insist, resist, or persist in their ways or opinions (i.e., behaviors commonly attributed to “stubbornness”)?

2. How do adult children’s responses to their parents’ behaviors affect depressive symptoms, their parent-child relationship quality, or the amount of general or caregiving support they provide to their aging parent(s)?

5.3 *Research Hypotheses*

First it was hypothesized that when adult children perceive their parents as insisting, persisting, and resisting (i.e., acting in a way commonly attributed to stubbornness), they would report using both direct (getting upset, arguing, or trying to reason) and indirect, passive approaches (letting it go, rewording their request, waiting, or getting someone else to ask) to respond to their aging parents. Children were expected to vary in the frequency of these responses, as would be evidenced by normally distributed reports across strategies (*Hypothesis 1*). Secondly, higher reports of use of direct response strategies by adult children of getting upset, getting into an argument, or trying to reason with a parent when perceiving their parent as acting in ways commonly attributed to stubbornness were expected to be associated with higher reports of depressive symptoms, lower relationship quality, less support to their aging parents, and less caregiving support (*Hypothesis 2a*). Conversely, higher reports of use of indirect response strategies by adult children of just letting their request go, wording their request differently, waiting and asking another day, or getting someone else to ask in response to parents’ stubbornness were expected to be associated with better mental health (fewer depressive symptoms, higher relationship satisfaction, more support to their aging parents, and more caregiving support) (*Hypothesis 2b*).
symptoms), higher relationship quality, greater support provided, and more caregiving help (Hypothesis 2b). (See Figure 5.1)

5.4 Method

Participants

Participants were 221 middle-aged adults (aged 45 to 65; 86 males, 135 females) who completed a second round of data collection for “The Family Exchanges Study” (see Fingerman et al., 2010). All middle-aged adults who participated in the initial survey that ran from January through August of 2008 were asked to complete a subsequent telephone survey between January and August of 2013. Potential middle-aged participants (N = 633; 302 men, 331 women) had at least one child over the age of 18, at least one living parent, and reported on exchanges of support within relationships at Wave 1. The middle-aged adults were asked about a total of 868 living parents (325 fathers, 543 mothers) at Wave 1 and a total of 290 living parents at Wave 2 (103 fathers, 187 mothers). Only those middle-aged adults still with a living parent were included in this sample (N = 221 of 289 who completed Wave 2). The final number of participants was dependent upon response rate and the number of adult children with parents still living. The sample included 61 (27.6%) African Americans and 160 (72.4%) non-African American individuals. Data presented here represent data from 34.91% of the eligible middle-aged adults contacted (N = 221 of eligible 633). (See Fingerman et al., 2010 for further details on sample)²

Procedure

This study consisted of second-wave telephone interviews utilizing structured survey questions with middle-aged adults as a component of the larger multi-stage “Family Exchanges

² Sample numbers will increase when I re-run analyses prior to paper submission for publication review. At that time there will also be more detailed statistics of response rate and retention for the overall sample.
Study,” looking at exchanges of varying forms of support in families. Individuals had participated in the larger study five years prior. All interested participants were asked a series of structured survey questions about a range of behaviors, thoughts, and beliefs. The primary purpose of the study was to capture the support exchange patterns among family members. However, in addition, middle-aged adults, whose parent(s) was/were alive, were asked about their perception and response to their mothers’ and/or fathers’ behaviors of resisting or insisting during the second wave of data collection (see Appendix H).

**Measures**

**Demographics.** Participants were asked to provide information on demographic characteristics. No specific hypotheses about demographic-based characteristics were proposed; but, individual level characteristics were controlled for to account for previously demonstrated relationships with the outcomes of interest (Birditt, Rott et al., 2009; Fingerman et al., 2010). Demographic control variables were examined in all analyses, including age, ethnicity, gender, education, and income. Ethnicity was coded as 0 (non-African American) and 1 (African American). Gender was coded as 0 (female) and 1 (male). Education was coded as 1 (no High School) to 5 (Post Graduate; \( M = 3.45, SD = 1.16 \)). Income was on a scale of 1 (less than $10,000) to 12 (250,001 or more; \( M = 6.52, SD = 2.77 \)). In the case of high intercorrelations among demographic variables, decisions were made regarding which variables to retain for analyses and entered into all models accordingly (i.e., income was highly intercorrelated with ethnicity and education and was dropped from analyses).

**Covariates.** Participants reported on their physical health and geographic distance from their parent(s) for each living parent. Models controlled for physical health due to its association with relationship quality (as done in Birditt, Rott et al., 2009) and geographic distance due to its
relationship with support provided (Fingerman et al., 2010). Physical health was coded from 1 *(poor)* to 5 *(excellent; M = 3.32, SD = 0.97)*. Distance was recorded in number of miles, and as done previously, log-linear transformed to correct for positive skew (mothers *M = 1.38, SD = 1.00*; fathers *M = 1.42, SD = 1.00*; Fingerman et al., 2010).

**Independent Measures.**

**Parent Stubbornness Measure.** A pilot measure of stubbornness was designed to ask a combination of fixed-choice and open-ended questions. Middle-aged adults (*N = 88*) were asked to provide words to describe a set of parental behaviors and how they respond to such behaviors. Based on frequency of responses and reliability estimates of scales from pilot results, the measure was pared down to a 22-item questionnaire (11 mother items; 11 father items) investigating the prevalence of and response patterns to reported stubbornness of elders by their adult children (see Appendix H).

The initial four stem questions ask the middle-aged participant the extent to which their father and/or mother exhibit(s) a specific behavior, on a likert scale from 0 *(Never)* to 4 *(Always)*. If participants endorsed at least one of the initial stem questions (e.g., “Does your father/mother ever insist on doing things his/her own way even if it makes his/her life more difficult?”), they were then asked to rate from 1 *(Never)* to 5 *(Always)* how upset these behaviors make them and how often they subsequently respond to such behaviors in a series of ways: *just let it go, argue with him/her, try to reason with him/her, try to word request differently, try to get someone else to convince mother/father to do or not do something, or wait and talk to him/her about it another day.* Stem questions were totaled to create a scale of frequency of behaviors commonly attributed to stubbornness, which is used as a control variable in the analyses articulated below (reports on mothers: *M = 6.07, SD = 3.71, α = .85*; reports on fathers: *M = 6.66, SD = 3.84, α*
The 7-items of response to perceived stubbornness were then examined individually, as in combination they did not load as a scale or as a set of scales, rather they acted as a ‘risk scale,’ in that endorsement of one response strategy reduced the likelihood of responding with another strategy. See Table 5.1 for mean item scores and distributions.

**Outcome Measures.**

**Depressive Symptoms.** Depressive symptoms were assessed for all participants utilizing 6-items of the Brief Symptom Inventory (BSI; Derogatis & Melisarator, 1983). Individuals were asked to report how much the following problems distressed or bothered them, during the past 7 days, including today: feeling lonely, blue, no interest in things, hopeless about the future, worthlessness, and depressed. Items were rated on a scale of 1 (not at all) to 5 (extremely) and were combined as a mean score, where higher scores indicate greater experience of depressive symptoms ($M = 1.47$, $SD = 0.68$, $\alpha = .90$).

**Relationship Quality.** Participants were asked 6-items on a scale of 1 (not at all) to 5 (a great deal) for each of their living parents. The scale consisted of two positive statements (e.g., how much does your father/mother understand you) and four negative statements (e.g., how much does your father/mother criticize you; Fingerman, Chen, Hay, Cichy, & Lefkowitz, 2006). Negative statements were reverse coded and averaged with the positive items to calculate an overall report of relationship quality for each parent. Higher scores indicate greater relationship quality. Mean report by middle-aged adults was 4.03 ($SD = 0.64$, $\alpha = .65$) for reports on relationship quality with mothers and 4.12 ($SD = 0.61$, $\alpha = .61$) for reports on fathers.

**Support Provided.** Total support provided by middle-aged adults to each of their aging parent(s) was measured utilizing the Intergenerational Support Scale (Fingerman et al., 2010). The scale consists of the mean item score of 7-items rated from 1 (less than once a year or not at
all), 2 (once a year), 3 (a few times a year), 4 (monthly), 5 (a few times a month), 6 (weekly), 7 (a few times a week), to 8 (daily), including: emotional support, technological support, practical support, talking about daily events, social support, providing advice, and financial support (see Fingerman et al., 2010 for further details on scale development). Higher scores indicate a greater amount of support provided (mothers: $M = 4.17$, $SD = 1.33$, $\alpha = .84$, fathers: $M = 3.25$, $SD = 1.44$, $\alpha = .87$).

**Caregiving.** Caregiving was conceptualized as providing regular assistance to an aging parent due to limitations with activities of daily living or independent activities of daily living. If participants in this sample indicated that their parents have a level of need for such care, they were then asked, How often do you help your father/mother with the tasks for which (s)he needs help on a scale of 1 (less than once a year or not at all), 2 (once a year), 3 (a few times a year), 4 (monthly), 5 (a few times a month), 6 (weekly), 7 (a few times a week), to 8 (daily). This question was utilized as a single item outcome variable for those that endorsed it (mothers: $n = 112$, $M = 4.68$, $SD = 2.19$, fathers: $n = 53$, $M = 4.36$, $SD = 1.98$).

**Data Preparation and Analysis Plan**

The goal of analyses was to first understand the prevalence of behavioral response patterns reported by middle-aged adult children when they perceive their parent(s) acting in a way commonly attributed to stubbornness and then to examine the association of such response patterns with individual and relationship-based outcomes (depressive symptoms, relationship quality, provision of support, and provision of caregiving support).

Stubbornness data were entered into the SPSS statistical program with all other relevant survey data from the project. Stubbornness data were cleaned, and, to address Hypothesis 1, descriptive statistics were run to understand the prevalence, range, and variance of adult
children’s response patterns to parents’ stubbornness. To address Hypothesis 2, child responses to parent stubbornness were then included as predictor variables in a set of regression analyses and a series of multi-level models. The goal was to see how differential responses relate to outcomes of depressive symptoms, relationship quality, provision of support, and provision of caregiving support.

More specifically, to address Hypotheses 2a, and 2b for the outcome of depressive symptoms, hierarchical multiple linear regression was utilized to examine the association of demographic and response variables with the outcome of adult child depressive symptoms. Two models were run, one for adult child reports of responses to mother’s stubbornness and one for adult child responses to father’s stubbornness. For the other three outcome variables (i.e., relationship quality, provision of support, and provision of caregiving support), multilevel models were utilized to account for the fact that parents and adult children were nested within families and that reports on mother’s and father’s behaviors were given by a shared reporter (middle-aged adult child; SAS PROC MIXED; Singer & Willett, 2003). Multilevel modeling accounts for the common association that is shared between reports on mothers and fathers due to characteristics of the reporter/family. To examine the relationship between response patterns with the outcomes of interest, multilevel models calculate two levels of variance: level 1 variance which accounts for within-person (middle-aged adults’ reports on each parent) regressions and residuals and level 2 variance which accounts for the average within-person effects or the between-person (i.e., from one middle-aged adult to the next) regressions and residuals (Kenny, Kashy, & Cook, 2006). Furthermore, random slopes were not estimated in the models as there were not enough lower level units to allow for slopes to vary within families,
rather the variance related to slope was compounded within the overall error variance (Kenny et al., 2006).

A series of models was completed for each of the additional three outcome variables: (1) relationship quality, (2) provision of support, and (3) provision of caregiving support. First, an unconditional means model, or empty model, with no predictors was run to examine the amount of within-person and between-person variance to be explained in each outcome variable:

\[
\text{Level 1: } \text{Outcome}_{ij} = \beta_{0j} + e_{ij}
\]
\[
\text{Level 2: } \beta_{0j} = \gamma_{00} + u_{0j} \quad \text{(Model 0)}
\]

where \(\text{Outcome}_{ij}\) is participant \(i\)’s expected score on the specified outcome when the intercept is 0, \(\beta_{0j}\) is participant \(i\)’s intercept parameter, \(e_{ij}\) are unobserved participant specific residual errors, and \(\gamma_{00}\) is the expected score of the participant’s outcome when both \(e_{ij}\) and \(u_{0j}\) (the standard deviation of the estimated intercepts) are zero. For each outcome variable, we used a heterogeneous compound symmetry (CSH) variance structure that treats the individual scores as repeated measures in a family but allows for heterogeneity in variance across family members (Kenny et al., 2006; Singer & Willett, 2003). We then used the RCORR estimate to interpret the Intraclass Correlation Coefficient (ICC) for between-families to examine the dispersion of within family (within-person) and between family (between-person) variation. For relationship quality 22% (ICC = .22) of the variance was attributed to similarities within families (i.e., differences between families), for support provided to parents 1% (ICC = .01) of the variance was attributed to similarities within families, and for caregiving support provided to parents 16% (ICC = .16) of the variance was attributed to similarities within families.

Second, the predictor variable of parent status was entered into the level 1 equation to account for any statistical differences in adult child’s reports of responses to parents’ behaviors
by parent (i.e., reports on mothers vs. fathers). Mother was coded as -1 and Father was coded as 1, such that 0 represented the mean level report across family.

**Level 1:** \( \text{Outcome}_{ij} = \beta_{0j} + \beta_{1j} (\text{PARENT}_{ij}) + e_{ij} \)

**Level 2:** \( \begin{align*} \beta_{0j} &= \gamma_{00} + u_{0j} \\ \beta_{1j} &= \gamma_{10} \end{align*} \)  

(Model 1)

where \( \text{Outcome}_{ij} \) is participant \( i \)'s expected score on the specified outcome when the intercept is 0, \( \beta_{0j} \) is participant \( i \)'s intercept parameter, \( e_{ij} \) are unobserved participant specific residual errors, and \( \gamma_{00} \) is the expected score of the participant’s outcome when \( \gamma_{10} \) is at its mean level and both \( e_{ij} \) and \( u_{0j} \) (the standard deviation of the estimated intercepts) are zero.

Third, demographic variables and covariates were entered into the base models as predictors for each outcome variable. These models included variables deemed appropriate for inclusion (i.e., independent predictors, not highly intercorrelated) at the within-family (within-person) level—geographic distance and prevalence of parent stubbornness—and the between-family (between-person) level—age, ethnicity, gender, physical health, and education). The models were set up as follows:

**Level 1:** \( \begin{align*} \text{Outcome}_{ij} = & \beta_{0j} + \beta_{1j} (\text{PARENT}_{ij}) + \beta_{pj} (X_{ij}) + e_{ij} \\ \beta_{pj} &= \gamma_{p0} \end{align*} \)  

(Model 2)

where \( W_{qj} \) are between-person predictors of the effects of \( \beta_{0j} \) with \( \gamma_{pqj} \) as the corresponding coefficients and \( X_{ij} \) are the within-family predictors with \( \gamma_{p0} \) as corresponding coefficients.

Model 2 for each outcome variable also included interaction terms of each demographic or control variable with parent status (mother or father), which are not included in the above listed equation, to account for the differential effects of demographic and control variables depending upon whether the reports are about mothers or fathers. To maintain parsimony in model fitting,
only significant interactions were retained moving forward, which indicate a differential effect of child reports for mothers versus fathers for the specified variable.

Fourth, to directly test Hypothesis 2a and 2b demographic and control variables were retained with any significant interactions with parent status and reports of responses to parental behaviors were entered into the model at Level 1 for each of the three outcome variables.

**Level 1:** \( \text{Outcome}_{ij} = \beta_{0j} + \beta_{1j} (\text{PARENT}_{ij}) + \beta_{pj} (X_{ij}) + \beta_{qj} (Z_{ij}) + e_{ij} \)

**Level 2:** \( \beta_{0j} = \gamma_{00} + \gamma_{p0} W_{qj} + u_{0j} \)

\( \beta_{1j} = \gamma_{10} \)

\( \beta_{pj} = \gamma_{p0} \)

\( \beta_{qj} = \gamma_{q0} \)

(Model 3)

where \( Z_{ij} \) refers to the added response variables (i.e., upset, let go, argue, reason, reword, wait, and get someone else) and \( \gamma_{q0} \) are the corresponding coefficients for each form of response pattern. As with demographic and control variables, interaction effects across parent status (mother or father) were also included to account for the differential effects of response strategies on the outcomes based on whether the adult child reported about their mother or father. Only significant interactions were retained in presented analyses.

In order to ease interpretation of significant interactions, post-hoc follow-up tests were run with multi-level models to test the effect for mothers and fathers separately. To do so, the final model of each above-articulated series of models was duplicated utilizing code containing an estimate statement for mothers and fathers separately for each significant interaction found. The use of these estimate commands provides effects and p-values for each parent’s reports to determine if a given effect is significant for reports on mothers, fathers, both, or neither.

In the end, the analyses included descriptive statistics, a set of multiple linear regressions (to test the effect on depressive symptoms), a series of multi-level models to determine the primary effects (4 for each of the outcome variables of relationship quality, support provided,
and caregiving support), and a series of post-hoc multi-level models with estimate commands to interpret interactions. The goal of analyses was to ultimately delineate the occurrence and effect of adult children’s differential responses to parents’ behaviors commonly attributed to stubbornness.

5.5 Results

The first hypothesis predicted that adult children would endorse responding to their parents’ behaviors of insisting, persisting, and resisting (i.e., behaviors commonly attributed to stubbornness) in direct (getting upset, arguing, or trying to reason) and indirect ways (letting it go, rewording their request, waiting, or getting someone else to ask). Basic descriptive statistics confirm this hypothesis, with 91% of the sample of adult children endorsing parent stubbornness and responses to those behaviors for at least one parent. Further, no adult child responded “(1) Never” to all response strategies listed. Most frequently children reported responding to elders’ behaviors to persist, insist, or resist by just letting their own requests go. Yet, children endorsed using a variety of both direct and indirect responses, and endorsement across all seven of the response strategies measured was normally distributed from 1 (Never) to 5 (Always), with no evidence of skew or kurtosis. (See Table 5.1)

Hypothesis 2 predicted that higher reports of using direct response strategies (e.g., getting upset, getting into an argument, or trying to reason) by adult children in response to parents’ stubbornness would be associated with higher reports of depressive symptoms, lower relationship quality, less support to their aging parents, and less caregiving support (Hypothesis 2a). In addition, it was expected that higher reports of using indirect response strategies (e.g., just letting it go, wording request differently, waiting and asking another day, or getting someone else to ask) by adult children in response to parents’ stubbornness would be associated with
better mental health (fewer depressive symptoms), higher relationship quality, greater support provided, and more caregiving help. Overall, results indicate that how adult children respond to their parents’ stubbornness is associated with both individual and relationship-based outcomes; yet, the effects differ depending upon whether the adult offspring was reporting on his/her father or mother. Furthermore, results only partially confirm the proposed pattern of effects hypothesized. We present the effects for each outcome variable below.

First, for the outcome of depression, when reporting on responses to mothers’ stubbornness, we see significant negative associations between the perception of mothers’ stubbornness and depressive symptoms (more stubbornness, less depressive symptoms) and child’s health and depressive symptoms (better health, less depression). In addition, when adult children report getting upset over their mothers’ stubbornness, letting their requests go with their mother, and/or more waiting to talk about a concern another day with their mothers they also report higher levels of depressive symptoms. For each one unit increase in getting upset there is 0.16 unit increase in depressive symptoms, for each one unit increase in letting go there is 0.13 unit increase in depression, and for each one unit increase in waiting there is a 0.15 unit increase in depressive symptoms. Additionally, higher reports of reasoning by adult children are significantly negatively related to depressive symptoms. For each one unit increase in the use of reasoning by adult children when they perceive their mothers as behaving in a way commonly attributed to stubbornness there is a 0.14 unit decrease in depressive symptoms. Meanwhile for fathers, when accounting for all response styles in the model, we see that the perception of fathers’ stubbornness is significantly related to depression in adult children (more stubbornness, more depressive symptoms). In addition, better health of the adult child is negatively related to
depression. But, no response strategies used with fathers have a significant relationship with depressive symptoms of the adult child (See Table 5.2).

Second, in regard to relationship quality, we find significant negative associations of parents’ stubbornness (more stubbornness, poorer relationship quality) and race (African Americans report lower relationship quality) with relationship quality. In addition, when adult children report better health they also report better relationship quality with their parent(s). Furthermore, when accounting for all response styles used when perceiving their parents as acting in a way commonly attributed to stubbornness in the model, adult children who report more arguing, more letting go, and/or more re-wording of their requests when there is goal conflict also report lower levels of relationship quality. For each one unit increase in the level of arguing by adult children with parents there is 0.17 unit decrease in relationship quality, for each one unit increase in letting go there is a 0.08 unit decrease in relationship quality, and for each one unit increase in rewording there is a 0.09 unit decrease in relationship quality (See Table 5.3).

Third, in regard to support provided, we find significant negative relationships with distance and support provided (further distance, less support) and child age and support provided (higher age, less support). We also find that the perception of parents’ stubbornness is not related to how much support is being provided. But, there is a differential effect of race on the amount of support provided for mothers and fathers (-0.40). Furthermore, when accounting for all response styles in the model, more arguing and more reasoning are significantly associated with higher levels of support provided. For each one unit increase in arguing there is 0.23 unit increase in providing support and for each one unit increase in reasoning there is a 0.26 unit increase in providing support. In the case of reasoning, there is also a significant interaction by
parent such that, there is a differential effect on mothers and fathers (+0.21). Further, while there is not a main effect for adult children’s responses of letting go of their requests on support provided, there is a significant interaction effect by parent (+0.16). (See Table 5.3) Post-hoc tests reveal that the differential effect of race on support provided for mothers and fathers is isolated to mothers, with African Americans reporting lower relationship quality as compared to non-African Americans when reporting about their mothers. Yet, the differential effect of reasoning for mothers versus fathers is driven by adult children’s reports on fathers. More reasoning is linked to more support provided to fathers, but not mothers. And, lastly, while the effect of letting go on support provided is statistically different by parent, the separate effects for mothers and fathers are not individually significant.

Last, in regard to caregiving support provided by adult children we again find a negative relationship with distance and support provided (further distance, less support). We also find that there is no significant relationship between parents’ stubbornness and support being provided (only a trend). Yet, being a male child is linked to giving more caregiving support in this sample. In addition, there is a significant interaction effect by parent regarding the effect of education on caregiving support provided (+0.28). When we examine response patterns in the context of one another we find that when adult children report more letting go with their parents they report less caregiving support provided. For each one unit increase in letting go there is 0.45 unit decrease in caregiving support provided. Additionally, while there is not a main effect for reasoning or arguing by adult children with caregiving support, there is an interaction by parent, such that there is a differential effect on mothers and fathers (reasoning: +0.39, arguing: -0.45). Post-hoc tests reveal that the effect of education on caregiving support is not actually significant for either parent, despite a significant difference of effect for mothers and fathers
(only trending for fathers). For the differential effect of arguing on caregiving support, we find that the response of arguing is significantly associated with caregiving support provided for both mothers and fathers, but the effect is in the opposite direction. For mothers, more arguing is linked to more caregiving support (+0.45), but for fathers more arguing is linked to less caregiving support (-0.45). In regard to the differential effect of reasoning, post-hoc tests reveal that the effect of reasoning is not significant for either parent, despite a difference between reports on mothers and fathers (only trending for mothers). See Table 5.4 for a summary of results found.

5.6 Discussion

The results of this study demonstrate two primary findings. (1) When adult children perceive their parents as resisting, insisting or persisting around daily tasks and goals, i.e., acting in a way commonly attributed to stubbornness, adult children respond in both direct and indirect ways (e.g., letting go, getting upset, trying to reason). And, (2) it is not just the perception of occurrence of behaviors that matters, but how adult children respond to parents’ behaviors commonly attributed to stubbornness that affects individual and relationship-based outcomes. These findings carry several implications for research and practice.

In regard to our first hypothesis and research question, focused on understanding how adult children respond to their parents when they see their parents as acting in a way commonly attributed to stubbornness, we find that children respond in a variety of direct and indirect ways. Adult children endorse getting upset, just letting the conflict go, trying to reason with their parent(s), getting into an argument with their parent(s), trying to word their request differently, trying to get someone else to convince their mother/father to do or not to do something, and waiting to talk about it another day. Furthermore, they endorse trying more than one of these
strategies to varying degrees with “just let it go” being most commonly endorsed. “Just let it go” may proxy in this case as an “exit strategy” that removes the adult child from a conflict. This is consistent with prior work that has found that older people are more likely to use loyalty strategies (i.e., doing nothing or waiting) while younger people use exit strategies (i.e., yelling) (Birditt & Fingerman, 2005). Further consistent with the literature on relationship tensions (Birditt et al., 2011; Birditt, Rott et al., 2009), we see within and between family differences in responses to behaviors attributed to stubbornness. Such differential responses may indicate that each individual and each family attempts to navigate such perceived parental behaviors differently and that each dyad of a middle-aged adult and parent may respond uniquely to goal conflict.

In regard to our second hypothesis and research question around the implications of response patterns, we found that after controlling for the frequency of perceived stubbornness by parents, differential response strategies by adult children were associated with both individual and relationship-based outcomes. The frequency of behaviors commonly attributed to stubbornness was significantly associated with fewer child depressive symptoms when reporting on mothers’ behaviors and more child depressive symptoms when reporting on fathers’ behaviors, and lower relationship quality. However, at least one form of response was also significantly associated with each of the outcomes of depressive symptoms, relationship quality, support provided, and caregiving support (see Table 5.4 for the pattern of results found). Ultimately, it appears that it is not just the perceived occurrence of stubbornness that matter, but the responses to such behaviors that affect well-being outcomes and support. Consistent with Haley’s (1963) discussion on defining relationships, as tension builds and one person sends a
message to define the relationship, another has to respond and accept or reject the definition. This cycle of response shapes current and future individual and relationship states.

As for the particular effects of response styles on the outcomes tested here, current literature informed the expectation that how a family member subsequently responds to a tense situation may be linked to relationship outcomes (Birditt, Rott et al., 2009). It has been found that employing passive avoidance or active destructive response strategies is linked to negative relationship-based outcomes (Birditt, Rott et al., 2009). In the case of depressive symptoms and relationship quality, more emotion-laden constructs, we see findings in line with this prior research regarding adult children’s responses to parents. For interactions with mothers, depressive symptoms are linked to the adult child’s act of getting upset, letting things go, or waiting. Similarly for relationship quality with mothers or fathers, if the adult child reports arguing, rewording, or letting things go more, they also see their relationship quality as lower.

Such findings do not confirm the hypotheses we outlined of direct response strategies resulting in poorer outcomes (higher depressive symptoms and lower relationship quality) and indirect response strategies resulting in better outcomes (fewer depressive symptoms and higher relationship quality). Yet, they are consistent with this prior finding of Birditt and colleagues (2009). It is likely that “letting it go” and “waiting” proxy for a passive avoidant response while arguing, getting upset, or even just re-wording a request are more active confronting responses. When adult children avoid the conflict brought on by their mothers’ stubbornness, or actively express an emotional response with their parent, they experience greater depression and lower relationship quality. However, it is unclear how the effect of reasoning fits into this understanding. It may be that reasoning represents a more patient, rational discussion of concerns as compared to other response strategies, which decreases depressive symptoms. To
this latter point, the use of more direct strategies has been perceived as more effective for addressing elders’ (over the age of 70) problem behaviors in past research (Morgan & Hummert, 2000) and therefore may carry implications here as well. Moreover, of interest is that the significant effects were only found for middle-aged adults’ reports on mothers regarding children’s depression. It could be that adult children, particularly daughters, have unique relationships with their mothers (Fingerman, 1996). Or, it could reflect that children are not as close to fathers and their interactions have less of an impact on child well-being (Umberson, 1992). However, despite non-significance, the magnitudes of the coefficients for the responses of waiting and reasoning are quite similar for fathers as compared to mothers. Children who wait more have more depressive symptoms, while those who reason more have less depression. Testing these effects on a larger subsample of children with living fathers ($n > 80$) may increase the statistical power to detect such effects. Further research is needed to truly parse out these differences.

For the third outcome variable examined in this study, amount of support provided to a parent, we find a different pattern of effects. The amount of support middle-aged adult children provide to their parents is significantly associated with how those children respond to their parents when there is conflict in goals and parents act in a way commonly attributed to stubbornness. When adult children argue more they provide more support to their parents. Additionally when adult children reason more, they provide more support to their fathers, but not their mothers. Again we see that the effects do not break out by ‘direct’ versus ‘indirect’ behavioral responses to parents. In the case of arguing it could be that providing support to parents is stressful which results in more tension that leads to arguments or, in the case of fathers, the need to reason more.
In regard to the final outcome variable, providing caregiving support, we find still another pattern of effects. More letting go is linked to less provision of caregiving support provided to parents, while more arguing is linked to more caregiving support being provided to mothers but less provided to fathers. In this case, letting go may again indicate a form of passive avoidance whereby the conflict is not resolved, leading to negative implications of less support provided or as articulated above, more depression and lower relationship quality. But arguing may actually be a tapping into more than one dimension. For example, arguing with fathers may be a destructive form of response that leads to further relationship conflict and less caregiving support being provided, or in the case of mothers it may instead proxy for an emotional investment in the caregiving relationship whereby ideas are hashed out rather than simply let go. Or, arguing could be associated with the stress related to caregiving and carry differential effects on one’s ability to care for his/her mother or father.

Such ambiguity in the meaning of the response strategies might have been clarified if we had information on whether the conflict of goals that results in parents’ insisting, resisting, or persisting is subsequently resolved by the response strategy employed by children. It may be the resolution (or lack thereof) brought on by the specified response strategy that results in the effects found in this study. Previous research has demonstrated with Alzheimer’s Disease that families using positive conflict resolution methods provide more help than families not using such strategies (Lieberman & Lawrence, 1999). Thus in this sample, it could be the resolution evoked from the response of arguing or letting go that results in the associations found. Furthermore, not captured here is the sequence of responses utilized that results in the outcome. For example, if a child always argues first and then just lets the tension go it might result in differential outcomes as opposed to someone who lets a conflict fester until it reaches a certain
intensity and then argues about it. Both instances would result in high rates of use of these response strategies. Further work should delineate how the sequence of responses to a given behavior of the parent unfolds to determine if a pattern of responses employed by an adult child evokes a pattern of responses from the aging parent and then a subsequent resolution. Or alternately, responses to conflict in goals may be linked to other relationship-based processes not measured in this study.

Beyond research implications, practical implications are also raised. Adult children are often called on to serve as advocates and supports of aging parents, particularly as older adults’ sense of autonomy and control is challenged in their later years (M. Baltes, 1995; 1996; Heckhausen & Schulz, 1995). The findings here indicate that how children respond to parents in the face of goal conflict in daily life is linked to resources that affect provision of care and support (mental health and relationship quality) and the actual provision of that help (general support and caregiving support). Adaptive interventions that design clinical support around each family’s unique risk factors and concerns may help families learn how to better navigate goal conflicts in relationships and care (Zarit, Femia, Kim, & Whitlatch, 2010). Prior research supports the idea that such interventions may prove particularly useful in helping families mitigate the negative effects of particular response strategies (Zarit et al., 2010). However, it would be interesting to test if families experiencing goal conflict would benefit most from formally structured dyadic sessions or informally structured interventions with clinician conversations in the current care system for elders. Ultimately, if there is a destructive response cycle in place, intervention might allow families to sort out conflict before adult children are called on in the future to respond to parents’ needs.
This study is not without limitation. Though the initial sample was a randomized probability sample of individuals, the subset of the sample who completed the second wave of the study were unique. These participants were willing to take part in a longitudinal investigation regarding support exchanges within their families, and they still had parents alive that they could report on. Secondly, the primary predictors (response strategies) and the outcome of caregiving were single-item constructs. Utilizing a scale of items may improve statistical inference and understanding of these phenomena in future inquiries. Third, the response strategies tested here were generated from a pilot study, but additional strategies may also exist in response to behaviors by parents commonly attributed to stubbornness. Inclusion of an open-ended response option would allow for further examination of possible missed constructs that could be more salient. Fourth, the relationships discussed here are retrospective and ask about general behaviors at one point in time. More could be learned from studying such patterns of behaviors over time and in specific situational contexts. Finally, this study only focused on adult children’s perceptions of their parents’ behaviors and their perceptions of their own responses. More could be learned from examining these individuals in the context of the dyad or family to which they belong, collecting reports from both parents’ and their children.

Overall, despite such limitations the findings here demonstrate that it is not just middle-aged adults’ perceptions of the occurrence of parents’ behaviors that matter. Rather, how adult children respond to conflicts in goals when parents insist, persist, or resist affects individual and relationship-based outcomes, as well as the care or support they provide to their aging parents. These findings are unique in the literature. They contribute to our understanding of how adult children and parents interact on a day-to-day basis. More specifically, they help us to begin to understand how adult children interact with their parents and the consequences of such actions
when they perceive their parents as acting in ways commonly attributed to stubbornness. Such phenomena in relationships where one party (e.g., the adult child) is likely to step in to provide care or support to the other (e.g., the parent), or is already doing so, and where the power in the relationship may be changing due to aging and/or disability, are important to understand to ultimately learn how to support families, as many will continue to take on caregiving roles in elders’ future. Future work should continue to examine how these sequences of responses play out in families with adult children and aging parents and how such responses affect individual and relationship outcomes. However, work should also extend findings by examining the older adult’s own reactions to children’s responses and the effect of children’s responses on older adults’ functioning and outcomes. In the end, such work and findings can improve our understanding and provide insight into how we can practically provide care and support for older adults and their families around issues of conflict in daily support-based goals.
Table 5.1

Middle-aged adult children’s responses to parents’ behaviors attributed to stubbornness

<table>
<thead>
<tr>
<th>Item</th>
<th>MOTHERS (n = 187)</th>
<th></th>
<th></th>
<th>FATHERS (n = 103)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>Range</td>
<td>Skewness (SE)</td>
<td>Kurtosis (SE)</td>
<td>M (SD)</td>
<td>Range</td>
</tr>
<tr>
<td>To what extent does it bother or upset you…?</td>
<td>2.91 (1.04)</td>
<td>1 to 5</td>
<td>-.10 (.19)</td>
<td>-.29 (.37)</td>
<td>2.84 (1.01)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>To what extent do you…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>… Just let it go?</td>
<td>3.32 (1.03)</td>
<td>1 to 5</td>
<td>-.41 (.19)</td>
<td>-.24 (.37)</td>
<td>3.42 (1.15)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>… Try to reason with him/her?</td>
<td>3.12 (0.92)</td>
<td>1 to 5</td>
<td>-.19 (.19)</td>
<td>.38 (.37)</td>
<td>2.94 (0.92)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>… Get into an argument with him/her?</td>
<td>1.83 (0.85)</td>
<td>1 to 5</td>
<td>.87 (.19)</td>
<td>.52 (.37)</td>
<td>1.83 (0.96)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>… Try to word your request differently?</td>
<td>3.03 (0.94)</td>
<td>1 to 5</td>
<td>-.02 (.19)</td>
<td>.14 (.37)</td>
<td>2.99 (0.96)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>… Try to get someone else to convince your father/mother to do or not do something?</td>
<td>2.52 (0.97)</td>
<td>1 to 5</td>
<td>.11 (.19)</td>
<td>-.31 (.37)</td>
<td>2.46 (1.00)</td>
<td>1 to 5</td>
</tr>
<tr>
<td>… Wait and talk to him/her about it another day?</td>
<td>2.73 (0.84)</td>
<td>1 to 5</td>
<td>-.35 (.19)</td>
<td>.21 (.37)</td>
<td>2.52 (0.91)</td>
<td>1 to 4</td>
</tr>
</tbody>
</table>
Table 5.2

The effect of adult child responses to parent behaviors attributed to stubbornness on adult child reports of depressive symptoms

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>SE$_B$</td>
<td>$\beta$</td>
<td>$B$</td>
</tr>
<tr>
<td>Intercept</td>
<td>3.44$^{***}$</td>
<td>0.60</td>
<td>--</td>
<td>2.64$^{***}$</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance</td>
<td>0.06</td>
<td>0.05</td>
<td>0.09</td>
<td>0.03</td>
</tr>
<tr>
<td>Child Health</td>
<td>-0.24$^{***}$</td>
<td>0.05</td>
<td>-0.35</td>
<td>-0.21$^{***}$</td>
</tr>
<tr>
<td>Child Age</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.12</td>
<td>-0.02</td>
</tr>
<tr>
<td>Child Race (1 = AA)</td>
<td>-0.23$^*$</td>
<td>0.11</td>
<td>-0.16</td>
<td>-0.17</td>
</tr>
<tr>
<td>Child Sex (1 = Male)</td>
<td>-0.08</td>
<td>0.10</td>
<td>-0.07</td>
<td>-0.05</td>
</tr>
<tr>
<td>Child Education</td>
<td>-0.06</td>
<td>0.04</td>
<td>-0.11</td>
<td>-0.06</td>
</tr>
<tr>
<td>Stubbornness</td>
<td>-0.02</td>
<td>0.02</td>
<td>-0.09</td>
<td>-0.05$^*$</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child gets upset</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.16$^*$</td>
</tr>
<tr>
<td>Child argues</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.01</td>
</tr>
<tr>
<td>Child reasons</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>-0.14$^*$</td>
</tr>
<tr>
<td>Child let's go</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.13$^*$</td>
</tr>
<tr>
<td>Child re-words request</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>-0.03</td>
</tr>
<tr>
<td>Child waits</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.15$^*$</td>
</tr>
</tbody>
</table>

$R^2$ 0.17 0.29 0.18 0.26
$\Delta R^2$ 0.13
$F$ 4.15$^{***}$ 4.27$^{***}$ 2.29$^*$ 1.78$^†$

Note. $^†p < .10$. $^*p < .05$. $^{**}p < .01$. $^{***}p < .001$. Models were run on middle-aged adult children’s responses on $n = 152$ Mothers and $n = 80$ Fathers who had complete data on all variables on interest. The response of “getting someone else to convince father/mother to do or not to do something” was dropped from all analyses, as it did not have any explanatory power for any outcome variable.
Table 5.3

The effect of adult child responses to parent behaviors attributed to stubbornness on adult child reports of relationship quality, support provided, and caregiving support provided

<table>
<thead>
<tr>
<th>Relationship Quality</th>
<th>Support Provided</th>
<th>Caregiving Support Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MODEL 1</strong></td>
<td><strong>MODEL 2</strong></td>
<td><strong>MODEL 3</strong></td>
</tr>
<tr>
<td>B</td>
<td>SE</td>
<td>B</td>
</tr>
<tr>
<td>Fixed effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>4.07***</td>
<td>0.04</td>
</tr>
<tr>
<td>Parent (Mother vs. Father)</td>
<td>0.05</td>
<td>0.04</td>
</tr>
<tr>
<td>Controls (Within-Family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic Distance</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Stubbornness</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Distance*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Stubbornness*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Controls (Between-Family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Race (1 = AA)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Age</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Gender (1 = Male)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Health</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Education</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Race*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child Education*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Within-Family Effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child gets upset</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child argues</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child reasons</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child let's go</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child re-words request</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child waits</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child argues*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child reasons*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Child let's go*Parent</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Random effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Var (1)</td>
<td>0.41***</td>
<td>0.04</td>
</tr>
<tr>
<td>Var (2)</td>
<td>0.37***</td>
<td>0.05</td>
</tr>
<tr>
<td>CSH</td>
<td>0.23†</td>
<td>0.12</td>
</tr>
<tr>
<td>-2 Log Likelihood</td>
<td>557.4</td>
<td>439.0</td>
</tr>
<tr>
<td>AIC</td>
<td>563.4</td>
<td>445.0</td>
</tr>
</tbody>
</table>

Note: †p < .10, *p < .05, **p < .01, ***p < .001. N = 221 middle-aged adult children (reports on n = 187 Mothers, n = 103 Fathers). Each analysis used available data for each outcome variable. Model 2 for each outcome variable tested interaction effects of PARENT*(var) for all demographic/control variables; non-significant effects were removed. Model 3 tested the interaction effect of PARENT*(var) for all within-person variables; non-significant effects were removed. The response of “getting someone else to convince father/mother to do or not to do something” was dropped from all analyses as it did not have any explanatory power for any outcome variable.
Table 5.4

The pattern of effects of adult child responses to parent behaviors attributed to stubbornness on adult child reports of depressive symptoms, relationship quality, support provided, and caregiving support

<table>
<thead>
<tr>
<th>outcome 1: child depressive symptoms</th>
<th>outcome 2: relationship quality</th>
<th>outcome 3: support provided</th>
<th>outcome 4: caregiving support</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER</td>
<td>FATHER</td>
<td>MOTHER</td>
<td>FATHER</td>
</tr>
<tr>
<td>Get upset</td>
<td>+</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Let it go</td>
<td>+</td>
<td>...</td>
<td>—</td>
</tr>
<tr>
<td>Argue</td>
<td>...</td>
<td>...</td>
<td>—</td>
</tr>
<tr>
<td>Reason</td>
<td>—</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Reword request</td>
<td>...</td>
<td>...</td>
<td>—</td>
</tr>
<tr>
<td>Wait and ask again</td>
<td>+</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Note: “—” represents a negative relationship, “+” represents a positive relationship, and “...” represents no relationship found.
Figure 5.1

Hypothesized consequences of child response patterns to parent’s behaviors attributed to stubbornness

*Note: Resistance refers to a conflict in care or relationship-based goals*
Chapter 6. Conclusion and Overall Discussion of Dissertation

In the field of human development and family studies there is often a focus on understanding the micro-level processes of family functioning on individual, relationship-based, and societal outcomes. However, such findings often carry implications for more macro-level constructs, impacting our understanding of how the human race grows, develops, and functions. This dissertation is a compilation of three studies that investigate the more micro-level family processes of how older adults influence the care and support they receive from family members. The findings, however, impact our understanding of three more macro-level processes: (1) how we might support and help dyads of older adults and adult offspring through intervention, (2) understanding opportunities for delivering person-centered care, and (3) expanding policies and forms of services available to support elders and their families.

Theory and prior research demonstrate the value of autonomy and control in the lives of older adults (Deci & Ryan, 2000), yet also articulate the challenges in doing so. In the context of older adulthood, the practice of supporting autonomy is often compromised by individuals’ loss of physical and social abilities and decreasing ability to assert primary control that is partnered with an increasing need for social support (P. Baltes, Freund, & Li, 2005; Heckhausen & Schulz, 1995; Nolan, Davies, Brown, Keady, & Nolan, 2004). Evidence suggests that for individuals living with dementia (Elliott, Gessert, & Peden-McAlpine, 2009), older adults in nursing homes (Persson & Wästerfors, 2008), and for elders in some families (Cicirelli, 2006), elders’ own views are often not taken into consideration. Rather, caregivers often take on a role with great power for negotiation and decision making in care for elders in an effort to do what is ‘best for them’ (Pyke, 1999; Wilkinson, 2001). However, family members do not always see eye-to-eye on what those decisions and goals should be. A mismatch in relationship or care goals likely
leads to tension and conflict. In such instances, caregivers may discount elders’ preferences with the use of ‘folk logic’, or accounts of their behavior that justify their actions as situationally appropriate (Persson & Wästerfors, 2008). Or elders may attempt to accomplish a goal and meet some resistance; they may then subsequently persistently attempt to re-assert their goals, views, or perspectives through actions or words (Freund, 2006; Wrosch, Heckhausen, & Lachman, 2000).

Study 1 of this dissertation takes a ground up approach to understanding this form of conflict. Through semi-structured interviews, aging parents and their adult daughters reflected on the experiences they have of seeing eye-to-eye and not seeing eye-to-eye with each other. In situations that went well, individuals simply said things worked, yet in other instances they reflected on conflicts in goals in care. Elders and their adult daughters shared experiences of wanting something done whereby the other party did not agree. Additionally, elders were described as insisting and resisting in their ways despite possible outcomes. Families discussed how a goal arose and then a series of ensuing responses would play out. Yet, resolutions were not always reached and when they were, they were reached through various strategies.

Study 2 confirmed the occurrence of such conflicts in families with survey-based quantitative data, indicating that parents see themselves as displaying behaviors of insistence, persistence, or resistance more when they have higher education, the child has lower education, and the parent gives more support to their child. Children endorsed perceiving such forms of goal conflict more when it was their father, parent disability was greater, they experienced stress in helping their parent, they utilized more avoidant coping responses in times of relationship conflict, and when higher levels of neuroticism were reported by the parent. Furthermore, there were discrepancies in the perceptions of such behaviors with children reporting higher levels of
resistant behaviors by parents than parents self-reported, which were related to children’s use of avoidant coping responses, parent gender, parent disability, and parents’ reports of the support they provide to their adult child. Study 3 then demonstrated that it is not just the occurrence of stubbornness that matters but the responses to such behaviors that carry implications for individual and relationship-based outcomes within families.

The findings in this dissertation provide consistent evidence of the need to support and help dyads of older adults and adult offspring through intervention. Dyadic-interventions work with both members of a family often through a series of sessions to address concerns related to cognitive impairment, mental health, and/or physical health (Hinrichsen, 1992; Martire, Lustig, Schulz, Miller, & Helgeson, 2004; Martire, Schulz, Helgeson, Small, & Saghafi, 2010; Whitlatch, Judge, Zarit, & Femia, 2006). The goal of such intervention techniques is often to bring both parties involved in care on board to a common set of goals and treatments in care. These clinical approaches have proved efficacious for situations with individuals with dementia (Whitlatch et al., 2006) and other chronic health conditions (Martire et al., 2004). The findings from this dissertation, however, suggest that families even providing minimal levels of assistance could also benefit from this form of support, as family members are often called upon as the first level of care and support for elders in times of need. Study 1 demonstrated that challenges around not seeing eye-to-eye are common in caregiving, but Study 2 validated this prevalence in a non-caregiving, intergenerational population and demonstrated a discrepancy in perception of parents’ responses to goal conflict. Meanwhile, Study 3 further demonstrated an effect of children’s response to parents’ behaviors when there are goal conflicts on individual and family functioning. Furthermore, the association of parent disability with the perception of behaviors by parents that are commonly attributed to stubbornness, in particular, was found across both
Study 1 and Study 2, with children perceiving more stubbornness by parents with greater disability and adult daughters reflecting on the need to step in to make unilateral decisions most frequently when there was a safety related concern brought on by the limited abilities of her parent. As an individual ages, the conflicts and tensions arising from decreased physical ability and the need for more social support will develop; therefore, learning how to communicate, negotiate, and problem solve with their loved ones even before this need arises will prove vital to all. Dyadic interventionists may consider addressing this possibly frustrating sequence of behaviors around goal conflict in sessions to see if training of specific response strategies may improve the relationship functioning or quality, and individual outcomes of each party involved. For example, families may help elders to cope with increasing loss by supporting them in the use of selection-optimization-compensation techniques and responding in ways that encourage what the elder can do while compensating where needed (Freund & P. Baltes, 1998). If families build a base of interacting in a healthy way pre-care, frustrations and stressors later in the care process may be decreased, enabling families to provide care longer and experience lower levels of stress and burden over time.

The findings also support the need for improved understanding of how to provide truly person-centered care to older adults. Person-centered care is defined as care where the person and his or her values are the focus and center of care delivery (Edvardsson & Innes, 2010). It is associated with supporting individuals’ autonomy in an attempt to allow individuals to be advocates for themselves. The findings from Study 1 demonstrate that adult daughter caretakers often step in to make decisions for their parent when there are conflicts in care around safety or health related concerns. Furthermore, parents were cited to most frequently “let go” or “walk away” from conflicts in care. Meanwhile Study 1 and Study 2 demonstrated that adult children
report higher frequencies of perceived stubbornness by parents than parents self-report. Such findings hint at the idea that adult children may be stepping in to make decisions for parents, are influencing parents to take a more passive role in decision-making when there is conflict, and/or are misattributing parents actions as resistive when parents have different perspectives of their own behaviors. This could indicate that person-centered care is not being delivered and that elders’ own views are not being taken into consideration. Such perceptions and responses by adult children are important, as children in particular are often key moderators in influencing the delivery of person-centered care. Actions by children that appear to be in the best interests of the parent may not actually be reflective of the older adults’ preferences, goals, or values. Medical ethics calls for the use of “substituted decision making” that acts on what the individual thinks the elder would want first, rather than what the person thinks would be best for the older adult. Finding ways to teach families the importance of this issue may be key in improving elders’ functioning, or preserving independent functioning of elders for longer periods of time. It may mean, however, that there is a need to reframe the discussion of “person-centered care” to “dyadic-centered care” (i.e., an elder and other individual) or even “family-centered care” (i.e., an elder and his or her family; Feinberg, 2012; Nolan et al., 2004) for older adults in need of social support. In such care an elder’s values and preferences would be adhered to with the support of his/her family and in balance with his/her family’s values and needs. If such understanding is developed earlier in relationships, pre-care, it may ease the transition period when elders’ shift to needing more support later in their life. From a social perspective, concrete education around how a family member can honor an elder person’s values and preferences in care is needed.
Last, the findings from this dissertation carry implications for expanding policy and delivery of services to elders. Individuals are growing older and living longer. They are also living with more illness, disability, and multiple chronic health conditions. As a result, the challenges of decreased efficacy in cultural resources partnered with biological decline are more pronounced than ever before (Baltes, 1997). Beyond formal care institutions, there is increasing pressure being placed on families, and middle-aged adults in particular, to take on care for elders oftentimes for extended periods of time. Additionally, with the continued increase in the number of women in the workforce and declining family size, the burden and stress associated with providing such care and support is likely to become even greater over time. Caregivers and care recipients will continue to grow in diversity and responsibility in light of these shifting demographic changes. As a result, creativity is needed to develop strategies and techniques to improve the resources available to families and elders. However, the political and social system has yet to get there. It is known that the cost of care associated with expanding such services is extremely high, and that if more older adults shift into living in nursing homes than stay at home, the strain on the Medicaid system will increase drastically. Ultimately, as policy makers continue to consider incentives to help older adults “age in place” and receive home-based care, they also need to address the lack of training and support that families have in their daily concerns of caring and supporting an elder at home in the community. Preliminary support was written into the new health care legislation of the Affordable Care Act to provide support to caregivers through training and to include them in service planning idea development (Feinberg & Reamy, 2011). But, the implementation of such support is unclear. In collecting data from families providing caregiving support and generalized family support, the findings of this dissertation demonstrate a need for incorporation of training and support within the service
system around dealing with micro-level behaviors and stressors inherent in family relationships that affect the day-to-day functioning of these individuals. For example, it appears essential to address the concerns of how you respond to an older adult who is resistive or how an older adult can advocate for his/her views without being perceived as resistive before other challenges can be mitigated. Services that offer more support to elders and their families on an “on call” daily basis, such as social work case management and training, may prove effective in decreasing daily stressors associated with care and produce benefits in health and well-being. If families are expected to continue to provide care and support, services and supports must be incentivized to support families at home.

In the end, the preliminary work here is a first step in developing a better understanding of how older adults and their adult children navigate conflicts in goals in their daily life and respond to issues commonly attributed to stubbornness. Many questions remain:

- What are the consequences of older adults’ actions of acting in a way that is commonly attributed to stubbornness (i.e., insisting/persisting/insisting)?

- What is the most beneficial response to stubbornness by family members or caregivers?
  If parents do walk away more often from goal conflict, is this a form of hidden power?
  Or are children using their more overt power they possess in decision making to influence and adjust their parents’ goals?

- Initial behaviors by elders evoke a pattern of responses within families. Is it just the responses that matter (i.e., the child attempts to reason with a parent) or the pattern of a series of responses (i.e., the child argues, then attempts to reason, then let’s go) that really matters for individual and relationship-based outcomes? How does the sequence of
responses to a given behavior of the parent evoke a pattern of responses from the aging parent and then a subsequent resolution?

- Does the response of “letting go” lead to conflict resolution or is it a form of passive avoidance? Or, is it actually the resolution evoked by the response that matters more than the response itself? And if it is the resolution, what constitutes a resolution when there are conflicts in care related goals? Does the definition of a resolution mean something different for an aging parent as opposed to an adult child? Do the actual goals of the individual shift when conflict occurs and if so, why and in what circumstances? And if not, what makes the individual stand his/her ground on his/her goal?

- Are these patterns of perceptions and effects isolated to family care and support or do professional caretakers also perceive elders as acting in a way that is commonly attributed to stubbornness and if so, how do professional caregivers respond? How do their responses impact the care provided to elders or caregivers’ understanding of older adults’ preferences? Do they rationalize restriction of preference-based care by using “stubbornness” as a label and “folk logic” for not adhering to elders’ values?

- And, a larger question of interest, how can we begin to create interventions, service-based programs, and policy initiatives that support families in mitigating the possible negative effects associated with navigating goal conflict?

Further research is needed to address these remaining concerns to ultimately address how we can provide ethical care to older adults. It will further prove necessary to keep an eye always toward the practical implications of such work—*what do findings mean in regard to how we can improve care for older adults.* For, at the heart of the issue is the need to understand how we can achieve social justice in care for older adults.
References


Appendix A.
Study 1 Participant Sign up

Interactions between aging parents and their adult children can be complicated. And, we know that they can cause stress. As a result, we want to try to better understand the ways in which adult daughters interact with their parent (or parent-in-law) on a day-to-day basis. We hope to learn more about ways to help people in such relationships.

Participation includes a one-time 60-90 minute interview with you in your own home or a place where you are comfortable. You will be asked some questions about your daily experiences with your relative and how you see some of your relative’s behaviors. We would also like to interview your relative separately, and any information you share will not be shared with your relative. While the information you provide will be invaluable to us, we will pay you each $20 upon completion of your interview as a token of our appreciation.

If you are interested in hearing more about the study or participating, please list your contact information under the line that describes you below:

I am a parent and my adult daughter or daughter-in-law provides me with help one time a week or more with activities such as grocery shopping, cooking, transportation, or just coming over to spend time with me. My contact information is as follows:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am an adult daughter or daughter-in-law and I help my parent or parent-in-law one time a week or more with activities such as grocery shopping, cooking, transportation, or just spending time with him or her. My contact information is as follows:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Phone Number</td>
<td>Best time(s) to call</td>
</tr>
<tr>
<td>(          )</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B.
Study 1 Adult Daughter Screener

(IF THE PARENT HAS ALREADY BEEN SCREENED GO TO DSCREEN0a, OTHERWISE READ THE FOLLOWING.)

Thank you for your interest in the study to look at elders’ influence in family care. Before we discuss the study further, I would like to ask you a few questions about your caring situation with your parent to make sure you are eligible to participate. (GO TO DSCREEN1)

**DSCREEN0a.** Your [RELATIVE] indicated that you may be willing to participate in a one-time interview as part of a research study with (him/her) that is looking at the ways in which adult daughters interact with their parent (or parent-in-law) on a day-to-day basis. May I tell you a bit more about the study and see if you are also interested in participating?

(0) NO ➔ We understand that this might not be for you. Thank you for your time. (END SCREEN)

(1) YES ➔ Participation includes a one-time 60-90 minute interview with you in your own home or a place where you are comfortable. You will be asked some questions about your daily experiences with your relative and how you see some of your relative’s behaviors. We will also interview your relative separately, and any information you share will not be shared with your relative. While the information you provide will be invaluable to us, we will pay you each $20 upon completion of your interview as a token of our appreciation.

**DSCREEN0b.** Would you be willing to participate with your [RELATIVE]?

(0) NO ➔ We understand that this might not be for you. Thank you for your time. (END SCREEN)

(1) YES ➔ Thank you. What this involves is scheduling a face-to-face interview at your home or other location in which you’d feel comfortable. I would like to schedule a time and date approximately one month after your [RELATIVE] is discharged from the Abramson Center Short-Term Rehabilitation to allow you both time to adjust back into the community first.

**DSCREEN0c.** When would be a good time to plan for this interview?

(SET UP TIME/DATE OR TIME TO CALL BACK TO SET UP TIME/DATE)

**DSCREEN0d.** Thank you. I will be in touch 3 days prior to the date we just discussed to confirm that this would still work for you. (GO TO DEND3)

**DSCREEN1.** Are you currently providing care on a regular basis to a parent of yours?

(0) NO (GO TO DEND1)

(1) YES

**DSCREEN2.** How often do you help this parent with the tasks for which he or she needs help?

(1) DAILY

(2) A FEW TIMES A WEEK

(3) WEEKLY

(4) A FEW TIMES A MONTH (GO TO DEND1)

(5) MONTHLY (GO TO DEND1)

(6) A FEW TIMES A YEAR (GO TO DEND1)

(7) ONCE A YEAR (GO TO DEND1)

(8) LESS THAN ONCE A YEAR OR NEVER (GO TO DEND1)
DSCREEN3. How are you related to the adult who you are providing care to?
(1) SHE IS MY MOTHER
(2) SHE IS MY MOTHER-IN-LAW
(3) HE IS MY FATHER
(4) HE IS MY FATHER-IN-LAW
(5) HE OR SHE IS ANOTHER RELATIVE OR FRIEND (SPECIFY WHO: _______ ; GO TO DEND1)

DSCREEN4. Do your currently live in the community (i.e., in your own home, apartment)?
(0) NO (SPECIFY WHERE: _______ ; GO TO DEND1)
(1) YES

DSCREEN5. Where (does/will) your [RELATIVE] live (upon discharge)?
(1) IN HIS/HER OWN HOME
(2) WITH ADULT DAUGHTER IN THE COMMUNITY
(3) WITH ANOTHER FAMILY MEMBER IN THE COMMUNITY
(4) IN A NURSING HOME OR ASSISTED LIVING (GO TO DEND1)
(5) OTHER (SPECIFY WHERE: _______ ; PENDING ANSWER GO TO DSCREEN6 OR DEND1)

DSCREEN6. For the purposes of this study we would like both you and your [RELATIVE] to participate. May we (call/speak with) your [RELATIVE] as well?
(0) NO (GO TO DEND1)
(1) YES (SPECIFY NAME: ______________)

DSCREEN7. What is the best way to reach your [RELATIVE]?
(1) IN-PERSON AT ABRAMSON SHORT-TERM REHABILITATION CENTER
(2) BY PHONE (SPECIFY PHONE NUMBER: _______________ AND BEST TIME TO CALL: ______________)

(IF INELIGIBLE (DSCREEN1 = 0, DSCREEN2 ≥ 4, DSCREEN3 = 5, DSCREEN4 = 0, DSCREEN5 = 4 OR NON-COMMUNITY RESIDENCE LISTED IN 5, OR DSCREEN6 = 0) GO TO DEND1; OTHERWISE IF ELIGIBLE GO TO DEND2.)

DEND1. Thank you for expressing interest in this study. However, I am very sorry, but unfortunately you are not eligible for this study. Due to the nature of the study, we are looking for adult daughters who… [LIST ELIGIBILITY CRITERION NOT MET]. I thank you for your time and wish you the best of luck with your [RELATIVE]. (END SCREEN)

DEND2. Thank you. Based on your responses, you are eligible for the study and I’d like to invite you and your [RELATIVE] to participate. What this involves is scheduling a face-to-face interview at your home or other location in which you’d feel comfortable. During the interview, I will ask you a series of questions about your experiences as a caregiver and your thoughts and feelings about a variety of topics, including questions about your daily interactions with your parent and how you see some of your parent’s behaviors. The interview should last about an hour to an hour and a half. The information that you’ll share is invaluable, and I could not thank you enough for it. But as a small token of appreciation for your time, I will be giving you $20. Would you be interested in participating in the study?
(0) NO → We understand that this might not be for you. Thank you for your time. (END SCREEN)
(1) YES → That is great! Thank you for agreeing to participate in this study. Pending your [RELATIVE]’s agreement to also participate I will call to schedule an interview time with you.
We will look to schedule a time and date approximately one month after your [RELATIVE] is discharged from the Abramson Center Short-Term Rehabilitation to allow you both time to adjust back into the community first.

**DEND3.** Before ending (our time/the call) today, I would like to confirm that the phone number I have is the best phone number to reach you at. I have written down the following phone number (CONFIRM NUMBER OR CORRECT IF NECESSARY). I also have that the best time to call is (INDICATE TIME RECORDED), is this still true for you?

- (0) NO (SPECIFY BEST TIME: _____________)
- (1) YES → Okay great.

**DEND4.** Do you have any questions for me at this point? (ANSWER QUESTIONS IF HAVE ANY) Thank you. You can expect to hear from me again shortly.

(UPON CONFIRMATION THAT BOTH DYAD MEMBERS ARE WILLING TO PARTICIPATE, CALL AND SCHEDULE INTERVIEW TIME, DATE, AND LOCATION WITH EACH PARTY SEPERATELY. IF ONLY ONE MEMBER OF THE DYAD AGREES TO PARTICIPATE, CALL THE OTHER AND THANK THEM FOR THEIR INTEREST BUT INDICATE THAT THEY ARE NO LONGER ELIGIBLE.)
Appendix C.
Study 1 Parent Screener

(IF THE ADULT DAUGHTER HAS ALREADY BEEN SCREENED GO TO PSCREEN0a, OTHERWISE READ THE FOLLOWING.)

Thank you for your interest in the study to look at elders’ influence in family care. Before we discuss the study further, I would like to ask you a few questions about your situation with your adult daughter to make sure you are eligible to participate. (GO TO PSCREEN1)

PSCREEN0a. Your daughter, [NAME OF DAUGHTER], indicated that you may be willing to participate in a one-time interview as part of a research study with her that is looking at the ways in which adult daughters interact with their parent (or parent-in-law) on a day-to-day basis. May I tell you a bit more about the study and see if you are also interested in participating?

(0) NO → We understand that this might not be for you. Thank you for your time. (END SCREEN)

(1) YES → Participation includes a one-time 60-90 minute interview with you in your own home or a place where you are comfortable. You will be asked some questions about your daily experiences with your daughter and how you see some of your behaviors. We will also interview your daughter separately, and any information you share will not be shared with your daughter. While the information you provide will be invaluable to us, we will pay you each $20 upon completion of your interview as a token of our appreciation.

PSCREEN0b. Would you be willing to participate with your daughter?

(0) NO → We understand that this might not be for you. Thank you for your time. (END SCREEN)

(1) YES → Thank you. What this involves is scheduling a face-to-face interview at your home or other location in which you’d feel comfortable. I would like to schedule a time and date approximately one month after you are discharged from the Abramson Center Short-Term Rehabilitation to allow you time to adjust back into the community first.

PSCREEN0c. When would be a good time to plan for this interview?

(SET UP TIME/DATE OR TIME TO CALL BACK TO SET UP TIME/DATE)

PSCREEN0d. Thank you. I will be in touch 3 days prior to the date we just discussed to confirm that this would still work for you. (GO TO PEND3)

PSCREEN1. Do you currently receive care on a regular basis from an adult daughter or daughter-in-law?

(0) NO (GO TO PEND1)

(1) YES

PSCREEN2. How often does your daughter or daughter-in-law help you with the tasks for which you need help?

(1) DAILY
(2) A FEW TIMES A WEEK
(3) WEEKLY
(4) A FEW TIMES A MONTH (GO TO PEND1)
(5) MONTHLY (GO TO PEND1)
(6) A FEW TIMES A YEAR (GO TO PEND1)
(7) ONCE A YEAR (GO TO PEND1)
(8) LESS THAN ONCE A YEAR OR NEVER (GO TO PEND1)
**PSCREEN3.** How are you related to your daughter or daughter-in-law who is providing you care?
(1) SHE IS MY DAUGHTER
(2) SHE IS MY DAUGHTER-IN-LAW
(3) SHE IS ANOTHER RELATIVE OR FRIEND (SPECIFY WHO: _______; GO TO PEND1)

**PSCREEN4.** Do you currently live in the community (i.e., in your own home, apartment)?
(0) NO (SPECIFY WHERE: _______; GO TO PEND1)
(1) YES

**PSCREEN5.** Does your (daughter/daughter-in-law) who is providing you with assistance live in the community (i.e., in her own home, apartment)?
(0) NO (SPECIFY WHERE: _______; GO TO PEND1)
(1) YES

**PSCREEN6.** For the purposes of this study we would like both you and your adult daughter who is providing you with assistance to participate. May we (call/speak with) your daughter as well?
(2) NO (GO TO PEND1)
(3) YES (SPECIFY NAME: __________)

**PSCREEN7.** What is the best way to reach your daughter?
(3) IN-PERSON AT ABRAMSON SHORT-TERM REHABILITATION CENTER
(4) BY PHONE (SPECIFY PHONE NUMBER: ______________ AND BEST TIME TO CALL: ______________)

(If INELIGIBLE (PSCREEN1 = 0, PSCREEN2 ≥ 4, PSCREEN3 = 3, PSCREEN4 = 0, PSCREEN5 = 0, OR SCREEN6 = 0) GO TO PEND1; OTHERWISE IF ELIGIBLE GO TO PEND2.)

**PEND1.** Thank you for expressing interest in this study. However, I am very sorry, but unfortunately you are not eligible for this study. Due to the nature of the study, we are looking for older adults who... [LIST ELIGIBILITY CRITERION NOT MET]. I thank you for your time and wish you the best of luck with your adult daughter. (END SCREEN)

**PEND2.** Thank you. Based on your responses, you are eligible for the study and I’d like to invite you and your daughter who is providing you assistance to participate. What this involves is scheduling a face-to-face interview at your home or other location in which you’d feel comfortable. During the interview, I will ask you a series of questions about your experiences with your daughter and your thoughts and feelings about a variety of topics, including questions about your daily interactions and how you see some of your behaviors. The interview should last about an hour to an hour and a half. The information that you’ll share is invaluable, and I could not thank you enough for it. But as a small token of appreciation for your time, I will be giving you $20. Would you be interested in participating in the study?
(0) NO → We understand that this might not be for you. Thank you for your time. (END SCREEN)
(1) YES → That is great! Thank you for agreeing to participate in this study. Pending your daughter’s agreement to also participate I will call to schedule an interview time with you. We will look to schedule a time and date approximately one month after you are discharged from the Abramson Center Short-Term Rehabilitation to allow you time to adjust back into the community first.
PEND3. Before ending (our time/the call) today, I would like to confirm that the phone number I have is the best phone number to reach you at. I have written down the following phone number (CONFIRM NUMBER OR CORRECT IF NECESSARY). I also have that the best time to call is (INDICATE TIME RECORDED), is this still true for you?

(2) NO (SPECIFY BEST TIME: _____________)
(3) YES  →  Okay great.

PEND4. Do you have any questions for me at this point? (ANSWER QUESTIONS IF HAVE ANY) Thank you. You can expect to hear from me again shortly.

_UPON CONFIRMATION THAT BOTH DYAD MEMBERS ARE WILLING TO PARTICIPATE, CALL AND SCHEDULE INTERVIEW TIME, DATE, AND LOCATION WITH EACH PARTY SEPARATELY. IF ONLY ONE MEMBER OF THE DYAD AGREES TO PARTICIPATE, CALL THE OTHER AND THANK THEM FOR THEIR INTEREST BUT INDICATE THAT THEY ARE NO LONGER ELIGIBLE._
Appendix D.
Study 1 Adult Daughter Interview Guide

Note: The guide represents a set of initial questions. In the interviews, the Principal Investigator will use follow-up questions to have respondents elaborate upon their initial answers. The order of questions is also not fixed, but dependent on how the family caregiver responds.

DQ1. First I’d like to understand a bit more about your caring situation with your [RELATIVE]. Why are you currently providing care for your [RELATIVE]?
   - DQ1a. Can you describe his/her health problems/needs?
   - DQ1b. What can and can’t your [RELATIVE] do on his/her own?
   - DQ1c. What do you help with?
   - DQ1d. Who else helps and what do they help with?
   - DQ1e. How long have your been providing care to your [RELATIVE]?

DQ2. What does a typical day in the life of caring for your [RELATIVE] look like? Describe how you help your [RELATIVE] on a given day.
   - DQ2a. How does any given day play out?
   - DQ2b. What goes well?
   - DQ2c. What doesn’t go well?

DQ3. When there are multiple people involved in making decisions in daily life, we know that things can be difficult. Some routines are established easily while others are not. We would like to hear more about how this works in your relationship.
   - DQ3a. Describe one instance where you did see eye-to-eye with your [RELATIVE].
     - What happened?
     - What did you do?
     - What went well?
     - Why was it easy?
   - DQ3b. Can you describe another instance when this has occurred?
     - What happened?
     - What did you do?
     - What went well?
     - Why was it easy?
   - DQ3c. Describe one past instance where you didn’t see eye-to-eye.
     - What happened?
     - People use different strategies when we do not see eye-to-eye with someone we care about—some strategies work, some strategies don’t work, and some strategies we are not always proud of. What did you do?
     - Why didn’t this go well?
     - How did you resolve this conflict?
   - DQ3d. Describe one present instance where you don’t see eye-to-eye.
     - What happens?
     - [IF NEEDED: People use different strategies when we do not see eye-to-eye with someone we care about—some strategies work, some strategies don’t work, and some strategies we are not always proud of. ] What do you do?
     - Why doesn’t this go well?
     - How have you tried to resolve this conflict?
DQ3e. [IF ALREADY MENTIONED START WITH: I know you already talked about this but…] Are there instances that your [RELATIVE] chooses to ignore something that you feel would make (his/her) life better, safer, or easier?
- Describe an example of when something like this happened.
- How did you feel?
- What did you do?
- How did it get resolved?

DQ3f. [IF ALREADY MENTIONED START WITH: I know you already talked about this but…] When you interact with your [RELATIVE], do you ever feel that your [RELATIVE] insists on doing things (his/her) own way even if it puts (him/her) at risk?
- Describe an example of when something like this happened.
- How did you feel?
- What did you do?
- How did it get resolved?

   DQ4a. What do you do if your [RELATIVE] complains (about something)?

DQ5. Do you, as a family caregiver, have the opportunity to complain if your [RELATIVE] is troublesome?
   DQ5a. To who and what do you complain about?

DQ6. Overall, is there anything else you think is important for me to know to understand how you and your [RELATIVE] have been navigating decisions around your [RELATIVE]’s daily care?
Appendix E.

*Study 1 Adult Daughter Demographic Questionnaire*

(UPON COMPLETION OF THE SEMI-STRUCTURED PORTION, FOR THOSE THAT WERE NOT ANSWERED DURING THE INTERVIEW, ASK THE PARTICIPANT NOW)

Now, some questions for statistical purposes.

**DDEMO1.** How old are you?

________YEARS

**DDEMO2.** Do you consider yourself to be Hispanic or Latin(o/a)?

(0) NO
(1) YES

**DDEMO3.** What race do you consider yourself to be? Select one or more of the following: (CODE ALL THAT APPLY.)

(1) ASIAN
(2) BLACK OR AFRICAN AMERICAN
(3) WHITE
(4) AMERICAN INDIAN OR ALASKA NATIVE
(5) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

**DDEMO4.** What is your marital status?

(1) MARRIED/PARTNER
(2) WIDOWED
(3) DIVORCED
(4) SEPARATED
(5) NEVER MARRIED

**DDEMO5.** What is the highest level of education you have completed?

(1) LESS THAN HIGH SCHOOL
(2) SOME HIGH SCHOOL
(3) HIGH SCHOOL GRADUATE
(4) SOME COLLEGE COURSEWORK
(5) COLLEGE GRADUATE
(6) GRADUATE DEGREE

**DDEMO6.** Do you provide any financial assistance to your [RELATIVE]?

(0) NO  (GO TO DEMO8A)
(1) YES

**DDEMO7.** Do you consider the amount of money you have to spend on caring for your [RELATIVE] each month to be:

(1) ABOUT WHAT YOU CAN AFFORD
(2) SOMewhat MORE THAN YOU CAN AFFORD
(3) MUCH MORE THAN YOU CAN AFFORD
(99) DON'T KNOW/REFUSED
DDEMO8A. Now I’d like to ask you some final questions about your [RELATIVE]’s memory and the difficulty (he/she) may have doing some things. How difficult is it for your [RELATIVE] to remember recent events?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8B. (How difficult is it for your [RELATIVE] to)…know what day of the week it is?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8C. (How difficult is it for your [RELATIVE] to)…remember (his/her) home address?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8D. (How difficult is it for your [RELATIVE] to)…remember words?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8E. (How difficult is it for your [RELATIVE] to)…understand simple instructions?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8F. (How difficult is it for your [RELATIVE] to)…find (his/her) way around the house?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DDEMO8G. (How difficult is it for your [RELATIVE] to)…speak sentences?

(0) NOT AT ALL DIFFICULT
(1) JUST A LITTLE DIFFICULT
(2) FAIRLY DIFFICULT
(3) VERY DIFFICULT
(4) CAN’T DO AT ALL

DEND. Thank you so much for your time today. The information you have provided is important to our understanding of interactions between adult daughters and their aging parents. To thank you for your time, we will pay you $20. (PAY PARTICIPANT AND HAVE PARTICIPANT SIGN RECEIPT). Please contact us if you have any questions about the study. You can contact me, Allison Reamy, at 703-727-6570. Additional contact information is on the consent form that you were given. Thank you again for your time.
Appendix F.
Study 1 Parent Interview Guide

Note: The guide represents a set of initial questions. In the interviews, the Principal Investigator will use follow-up questions to have respondents elaborate upon their initial answers. The order of questions is also not fixed, but dependent on how the aging parent responds.

PQ1. First I’d like to understand a bit more about your situation with your daughter. Why does your daughter currently provide you with assistance?
   - PQ1a. Can you describe your health problems/needs?
   - PQ1b. What can and can’t you do on your own?
   - PQ1c. What do you receive help with?
   - PQ1d. Who else helps and what do they help with?
   - PQ1e. How long have your been receiving assistance from your daughter?

PQ2. What does a typical day where your daughter assists you look like? Describe how your daughter helps you on a given day.
   - PQ2a. How does any given day play out?
   - PQ2b. What goes well?
   - PQ2c. What doesn’t go well?

PQ3. When there are multiple people involved in making decisions in daily life, we know that things can be difficult. Some routines are established easily while others are not. We would like to hear more about how this works in your relationship with your daughter.
   - PQ3a. Describe one instance where you did see eye-to-eye with your daughter.
     - What happened?
     - What did you do?
     - What went well?
     - Why was it easy?
   - PQ3b. Can you describe another instance when this has occurred?
     - What happened?
     - What did you do?
     - What went well?
     - Why was it easy?
   - PQ3c. Describe one past instance where you didn’t see eye-to-eye.
     - What happened?
     - People use different strategies when we do not see eye-to-eye with someone we care about—some strategies work, some strategies don’t work, and some strategies we are not always proud of. What did you do?
     - Why didn’t this go well?
     - How did you resolve this conflict?
   - PQ3d. Describe one present instance where you don’t see eye-to-eye.
     - What happens?
     - [IF NEEDED: People use different strategies when we do not see eye-to-eye with someone we care about—some strategies work, some strategies don’t work, and some strategies we are not always proud of.] What do you do?
     - Why doesn’t this go well?
     - How have you tried to resolve this conflict?
PQ3e. [IF ALREADY MENTIONED START WITH: I know you already talked about this but…] Are there ever instances that you choose to ignore suggestions or advice from your daughter that you know may make your life better, safer, or easier?
- Can you give me an example of when something like this happened?
- How did you feel?
- What did you do?
- How did it get resolved?

PQ3f. [IF ALREADY MENTIONED START WITH: I know you already talked about this but…] When you interact with your daughter, do you ever insist on doing things your own way even if you know it may make your life more difficult or unsafe?
- Can you give me an example of when something like this happened?
- How did you feel?
- What did you do?
- How did it get resolved?

PQ4. Do you ever complain about things? Tell me about it.

PQ4a. What does your daughter do if you complain (about something)?

PQ5. Does your daughter complain?

PQ5a. To who and what does she complain about?

PQ6. Overall, is there anything else you think is important for me to know to understand how you and your daughter have been navigating decisions around your daily care?
Appendix G.

Study 1 Parent Demographic Questionnaire

(UPON COMPLETION OF THE SEMI-STRUCTURED PORTION, FOR THOSE THAT WERE NOT ANSWERED DURING THE INTERVIEW, ASK THE PARTICIPANT NOW)

Now, some questions for statistical purposes.

PDEMO1. How old are you?
   ________YEARS

PDEMO2. Do you consider yourself to be Hispanic or Latin(o/a)?
   (0) NO
   (1) YES

PDEMO3. What race do you consider yourself to be? Select one or more of the following: (CODE ALL THAT APPLY.)
   (1) ASIAN
   (2) BLACK OR AFRICAN AMERICAN
   (3) WHITE
   (4) AMERICAN INDIAN OR ALASKA NATIVE
   (5) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

PDEMO4. What is your marital status?
   (1) MARRIED/PARTNER
   (2) WIDOWED
   (3) DIVORCED
   (4) SEPARATED
   (5) NEVER MARRIED

PDEMO5. What is the highest level of education you have completed?
   (1) LESS THAN HIGH SCHOOL
   (2) SOME HIGH SCHOOL
   (3) HIGH SCHOOL GRADUATE
   (4) SOME COLLEGE COURSEWORK
   (5) COLLEGE GRADUATE
   (6) GRADUATE DEGREE

PEND. Thank you so much for your time today. The information you have provided is important to our understanding of interactions between adult daughters and their parents. To thank you for your time, we will pay you $20. (PAY PARTICIPANT AND HAVE PARTICIPANT SIGN RECEIPT). Please contact us if you have any questions about the study. You can contact me, Allison Reamy, at 703-727-6570. Additional contact information is on the consent form that you were given. Thank you again for your time.
Appendix H.
Study 2 *Adult Child Target Parents’ Stubbornness Questionnaire*

Mother Questions: (ASKED IF MOTHER IS LIVING)

We are also interested in your perceptions of how your mother acts currently (as in the past few months).

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent does your mother ever ignore suggestions or advice from you that would make her life better, safer, or easier?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. To what extent does your mother ever <em>ignore or refuse</em> to do what her doctor tells her to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. To what extent does your mother ever <em>insist on doing things her own way</em> even if it makes her life more difficult or unsafe?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. To what extent does your mother ever <em>insist on doing things her own way</em> even if it makes someone else’s life more difficult, inconvenienced, or unsafe?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

(IF PARTICIPANT RESPONDED NEVER = 1 TO QUESTIONS 1, 2, 3, & 4, SKIP TO NEXT SECTION)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. To what extent does it bother or upset you when your mother <em>ignores suggestions or advice</em> or <em>insists on doing things her own way</em>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. When your mother <em>ignores suggestions or advice</em> or <em>insists on doing things her own way,</em> to what extent do you do the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...Just let it go?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. ...Try to reason with her?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. ...Get into an argument with her?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. ...Try to word your request differently?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. ...Try to get someone else to convince your mother to do or not do something?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. ...Wait and talk to her about it another day?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Father Questions: (ASKED IF FATHER IS LIVING)**

We are also interested in your perceptions of how your father acts currently (as in the past few months).

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To what extent does your father ever <strong>ignore suggestions or advice from you</strong> that would make his life better, safer, or easier?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>To what extent does your father ever <strong>ignore or refuse</strong> to do what his doctor tells him to do?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>To what extent does your father ever <strong>insist on doing things his own way</strong> even if it makes his life more difficult or unsafe?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>To what extent does your father ever <strong>insist on doing things his own way</strong> even if it makes someone else’s life more difficult, inconvenienced, or unsafe?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**(IF PARTICIPANT RESPONDED NEVER = 1 TO QUESTIONS 1, 2, 3, & 4, SKIP TO NEXT SECTION)**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>To what extent does it bother or upset you when your father <strong>ignores suggestions or advice</strong> or <strong>insists on doing things his own way</strong>?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>When your father <strong>ignores suggestions or advice</strong> or <strong>insists on doing things his own way</strong>, to what extent do you do the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>…Just let it go?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>…Try to reason with him?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>…Get into an argument with him?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>…Try to word your request differently?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>…Try to get someone else to convince your father to do or not do something?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>…Wait and talk to him about it another day?</td>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix I.  
Study 2 Parent Stubbornness Questionnaire

We are interested in your perceptions of yourself. To what extent are the following statements true for you:

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never</strong></td>
<td><strong>Rarely</strong></td>
<td><strong>Sometimes</strong></td>
<td><strong>Often</strong></td>
<td><strong>Always</strong></td>
<td></td>
</tr>
<tr>
<td>1. Thinking about your behavior in general (over the last few months), to what extent do you ever <strong>ignore suggestions or advice from</strong> (TARGET) that you know may make your life better, safer, or easier?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. To what extent do you ever <strong>ignore or refuse</strong> to do what your doctor tells you to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. To what extent do you ever <strong>insist on doing things your own way</strong> even if you know it may make your life more difficult or unsafe?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. To what extent do you ever <strong>insist on doing things your own way</strong> even if you know it makes someone else’s life more difficult, inconvenienced, or unsafe?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. People can push me just so far and then I have to take a stand.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I have a stubborn streak in me on certain things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Now, on a scale from 1 to 10 with 1 being “flexible” and 10 being “stubborn, how would you rate yourself?</td>
<td>---Flexible-----------------------------------Stubborn---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Allison Michelle Reamy

Department of Human Development and Family Studies
The Pennsylvania State University
101 Beecher-Dock House, University Park, PA 16802

Phone: 703-727-6570
E-mail: amr383@psu.edu

EDUCATION
Ph.D. The Pennsylvania State University, State College, PA (December 2013)
Human Development & Family Studies

M.S. Saint Joseph’s University, Philadelphia, PA (May 2009)
Experimental Psychology

B.S. Saint Joseph’s University, Philadelphia, PA (May 2008)
Psychology, Minor: Faith Justice (Summa Cum Laude)

HONORS AND AWARDS (GRADUATE STUDIES)
June 2013 Hoffman Summer Intern Scholarship Recipient
2012-2013 Kligman Graduate Fellowship Endowment Recipient
2009-2012 Graduate Teaching and Research Assistantship Recipient (The Pennsylvania State University)
Fall 2009 Donald H. Ford Endowment Recipient
2007-2009 Children’s Hospital of Philadelphia/Saint Joseph’s University Fellowship Recipient

RESEARCH EXPERIENCE
2012-2013 Research Intern, The Abramson Center for Jewish Life, Polisher Research Institute, North Wales, PA

2009-2013 Graduate Research Assistant, Human Development and Family Studies, The Pennsylvania State University, University Park, PA


TEACHING EXPERIENCE
2009-2011 Graduate Teaching Assistant, Human Development and Family Studies, The Pennsylvania State University, University Park, PA (Intervention Science; Resolving Problems; Adult Development and Aging)

PUBLICATIONS


