



Singaporean caregivers' experiences of placing a relative into long term care.

Journal:	<i>Clinical Gerontologist</i>
Manuscript ID:	WCLI-2014-0033.R3
Manuscript Type:	New and Emerging Professionals
Date Submitted by the Author:	11-Jul-2015
Complete List of Authors:	Ramanathan, Rajini; James Cook University Singapore, Psychology
Keywords:	caregivers, long-term care, caregiver stress < stress, older adult, placement < interventions

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CAREGIVERS' EXPERIENCES OF INSTITUTIONALISATION

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RUNNING HEAD: CAREGIVERS' EXPERIENCES OF INSTITUTIONALISATION

Singaporean caregivers' experiences of placing a relative into long term care.

Rajini Ramanathan and Paul Fisher

Author's note: This research project was conducted as part of the requirements for the submission of a Doctorate in Clinical Psychology.

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Abstract

Caregivers experience many difficulties and challenges with the process of providing care particularly at times of transition, such as when the care recipient moves into a nursing home. This qualitative study aims to understand caregiver experiences of this important process. Twelve interviews were conducted with caregivers with an older relative in a nursing home. Thematic analysis identified five themes: Filial and cultural expectations shape caregivers' experience of pre-placement decisions and post-placement; View of the placement decision; Continued impact of caring; Engagement with the institution and Maintaining the relationship. The findings and the post-placement implications are discussed.

Key words: caregiver, older adult, long term care, culture, filial piety, transition.

Singaporean caregivers' experiences of placing a relative into long term care.

Caregiving for an older relative is a demanding process that often comes at a high personal cost for the caregiver (Dellasega & Mastrian, 1995). Caregivers experience increased levels of stress, physical and psychological risk, a higher mortality rate and greater social isolation in contrast to their non-caregiving counterparts (Chene, 2006; Friss Feinberg & Goldstein, 2008; Schulz & Beach, 1999; Spector & Tampi, 2005; Vitaliano, Zhang, & Scanlan, 2003). However, despite these repercussions, caregivers also describe positive outcomes of caregiving, including lower scores of depression, burden and increased positive evaluations of their own health (Cohen, Colantonio & Vernich, 2002) better cognitive outcomes such as greater achievements on memory and processing speed tests (Bertrand, Saczynski, Mezzacappa, Hulse, Ensrud, & Fredman, 2012). Relational rewards of the role include companionship, while increased personal mastery leads to a sense of meaningfulness, fulfillment, and the opportunity to perform caregiving duties (Cohen, Colantonio & Vernich, 2002).

Caregiving is a dynamic process often described in the literature as a 'career' marked by "shifts in activities and stresses" (Pearlin, 1992, p.647) with transitions and diverse trajectories (Gaugler & Teaster, 2006). The decision to place the older relative into long-term care (LTC) represents an important transitional phase in which the caregiver is faced with an evolving set of roles and demands (Fleming, 1998; Gaugler, Mittelman, Hepburn, & Newcomer, 2010; Skaff, Pearlin, & Mullan, 1996) rather than a termination of their existing duties. However, caregiver outcomes following placement are varied. While there is decreased strain, stress and role overload (Gaugler *et al.* 2010), certain groups of caregivers, such as spouses and daughters, report increased distress (Butcher, Holkup, Park, & Maas, 2001). Other caregivers experience increased depression and anxiety consistent with those continuing to provide care in the community (Schulz *et al.*, 2004) suggesting that not all

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3 difficulties may be resolved by institutionalisation. When faced with the decision to continue,
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5 share or relinquish caregiving, caregivers were driven by their one of two caregiving
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7 purposes. First, interrelational objectives included protecting or maintaining the care
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9 recipient's sense of self and the caregiver-care recipient relationship. Second, pragmatic
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11 objectives included providing the care recipient with physical comfort, assuring high levels of
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13 care and minimizing the costs of caregiving. Key transitions often denoted changing
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15 emphases in each of these areas. For many caregivers, the decision to relinquish or continue
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17 caregiving at home was driven by the desire to maintain the relationship with the care
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19 recipient and the experience of caregiving is a complex social process with unique meaning
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21 for the caregiver (Caron & Bowers, 2003).
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25 Transition to LTC is an emotionally difficult process for the caregiver. Reuss, Dupuis
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27 and Whitfield (2005) identified three temporally based transition experiences as well as four
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29 continually occurring factors. Critical time points include the wait for admission, preparation
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31 for the move, and ease of the move. Four further conditions were relevant throughout the
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33 process – namely, the quality of communications, control over the process, support received,
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35 and caregiver and care recipient perceptions including the acceptance of the placement.
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37 Nolan and colleagues (1996) also identify four factors important in supporting the placement
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39 decision – anticipation of the move through forward planning and conscious decision making,
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41 a continuum of participation, exploration of alternate solutions, and ensuring sufficient
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43 information to facilitate the decision.
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47 Most of the research to date has been driven by studies based on Caucasian
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49 populations in America or Western Europe (Milne & Chryssanthopoulou, 2005). The
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51 literature arising from Asian studies is focused on earlier phases of placement such as on
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53 decision making (Chang & Schneider, 2010; Park, Butcher & Maas, 2004), but is limited in
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55 illuminating the Asian experience in caregiving during the transitional phase, or on post-
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3 placement caregiving. It is unclear how findings and theories on coping, accessing social
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5 support, early identification of increasing needs, and expression of negative effects of
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7 caregiving which arise from studies based on Western populations can be applied to other
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9 groups such as Asian caregivers (Milne & Chryssanthopoulou, 2005) who possess culturally
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11 unique coping and social support resources, experience stressors and appraise situations and
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13 outcomes, (e.g. caregiving burden, mental and physical health) differently from their Western
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15 counterparts (Kim & Lee, 2003; Knight & Sayegh, 2010; Pinguart & Sorensen, 2005).
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17 Different cultural groups also vary in terms of demographic profiles, (e.g. kinship, age,
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19 gender) (Pinguart & Sorensen, 2005), and multigenerational living arrangements, suggesting
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21 that culture and ethnicity differences are significant factors (Dilworth-Anderson, Williams &
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23 Gibson, 2002). Knight and Sayegh, (2010) argue that the importance of cultural values was
24
25 moderated by coping and social support, rather than serving as mechanism for the appraisal
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27 of caregiving burden. However, this was not confirmed in studies of Chinese Americans.
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29 Instead, the relationship between culture and coping was unclear. Chang, Schneider and
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31 Sessanna (2011) review the decisional making differences between Western individualist
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33 societies in contrast to Asian collectivism and reflect on the predictive validity of applying
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35 theories cross-culturally. Accounting for cultural beliefs and norms – which determine how a
36
37 society defines ageing, the caregiving role and expectations of family members – leads to a
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39 better conceptualisation of the issue among differing ethnic groups.
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46 Within Asia, Singapore's unique caregiving context arises from cultural values that
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48 are a blend of East and West (Foo, Merrick & Kanzantiz, 2006). Although retaining Asian
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50 values of collectivism, interdependence, and familism (Foo, Merrick & Kanzantiz, 2006),
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52 greater exposure to the English language (D'Rozario & Romano, 2000), colonial rule and
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54 modernisation (Cheung & Kwan, 2009) have differentiated Singaporeans culturally from
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56 their counterparts in East Asia. The Singapore government has actively encouraged "ageing
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3 in place” as the primary means of supporting the rapidly growing aging population where the
4 family is the first line of support for the emotional and physical needs of older adults
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7 (Ministerial Committee for Aging, 2007). Caregiving largely falls upon family caregivers,
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9 specifically second-generation female members (i.e. daughters or daughters-in-law) (Chee,
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11 Li, Luo, Wai & Yap, 2010). Most older adults in Singapore live with their children who
12 subsequently take on the caregiving role (Mehta, 2005; Malhotra, Malhotra, Ostbye, Matchar,
13 & Chan, 2012). This is unique as compared to Western caregiving arrangements, where most
14 caregivers are spouses, or children who live independently (Finlayson & Cho, 2008;
15 Bragstad, Kirkevold, Hofoss, & Foss, 2014). As a result, there is a strong social responsibility
16
17 for family members to perform a caregiving role, and LTC facilities are generally seen as
18 unfavourable options although this opinion is gradually changing (Sitoh, 2003). Indeed, there
19 is specific legislation in Singapore, the Maintenance of Parents Tribunal Act, which requires
20 children to provide for their older parents and allows parents to seek legal redress in the event
21 of failure to do so. Additionally, LTC and other day care support services in Singapore is
22 more expensive than in Western countries (Chee et al., 2010) making it a less viable option
23 for many caregivers.
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38 Using a qualitative methodology, this paper aims to explore how Singaporean
39 caregivers' retrospective experience of the process of placing their older relative into an LTC
40 and their continued involvement post-placement.
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45 Method

46 Design

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48 A thematic analysis of interview data (Braun & Clarke, 2006) was chosen for the
49 detailed exploration of caregivers' experiences of admitting a relative into LTC. Thematic
50 analysis is defined as a means of “identifying, analysing and reporting” (p.79) trends within a
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3 data set (Braun & Clarke, 2006) where important concepts emerge in the description of the
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5 phenomenon in question (Fereday & Muir-Cochrane, 2006).
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7 8 **Participants**

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10 A nursing home in Singapore, with approximately 280 older adult residents aged 60
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12 and above, provided the location for this study.

13
14 Twelve family caregivers of the residents were recruited. This sample has been shown
15
16 to be appropriate for a thematic analysis (Braun & Clarke, 2006; Fisher, Johnstone, &
17
18 Williamson, 2011) as data saturation can be reached within six interviews (Guest, Bunce, &
19
20 Johnson, 2006). Additionally, as recommended by Morse (2000), the sample size of a
21
22 qualitative study is influenced by a narrowly defined scope of enquiry and amount of useful
23
24 data each participant shares. "Caregiver" was defined as the individual with whom the
25
26 resident had lived and depended on for activities of daily living (ADL) (McConnell, 2001)
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28 prior to admission. Potential participants met the following inclusion criteria if they were a) a
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30 relative of the care recipient, b) above 18 years of age years upon the care recipient's
31
32 placement, c) involved in caregiving prior to placement and in the decision to place the care-
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34 recipient, and d) could communicate in simple English. Table 1 provides a summary of
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36 participant profiles.
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40 < Insert Table 1 about here >
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43 Participants reported differing lengths of time since the placement of the care
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45 recipient. While this was derived through convenience rather than purposive sampling
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47 processes, this variance among the current participants serves to identify core experiences
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49 among the caregivers.
50

51 52 **Procedure**

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3 **Recruitment.** Nursing home staff approached family members to raise awareness of
4 the study and mailed letters of invitation to caregivers. Interested potential participants
5 contacted the first author, who verified their eligibility and explained the study to them.
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9 **Data collection.** Signed informed consent was obtained at the start of each interview.
10 Participants were interviewed in a location of their choosing (e.g. their homes or a private
11 location at the nursing home). Interviews were conducted in Standard English, although some
12 participants responded in colloquial Singaporean English. Interviews, lasting between 45
13 minutes to 100 minutes, were audio-recorded. The interview focused on the decision to
14 institutionalise. It began with the question “Tell me about the time you decided to put your
15 (relative) in the home” and then progressed following a flexible semi-structured interview
16 schedule, based on the procedure described by Butcher, Holkup, Park and Maas (2001) and
17 Strang and colleagues (2006). Participants were given the lead in the interview to share
18 experiences they felt were pertinent. Prompts were used to clarify responses when necessary
19 (e.g. about making the decision, difficulties and concerns regarding placement). Participants
20 were given a S\$20 supermarket voucher in appreciation.
21
22

23 **Data Analysis.** The first author transcribed the audio-recordings verbatim. Analysis
24 was performed using NVIVO 9 computer software package (QSR International), which
25 allows for greater auditability of the process and outcomes of the analysis, thereby increasing
26 the credibility of the analysis (Butcher, *et al.* 2001). .
27
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29 The procedure described by Braun and Clarke (2006) was followed. At stage one,
30 after a close reading of the transcripts, the first author identified all relevant quotes as
31 potential data extracts and generated codes to represent the meaning within the data deemed
32 to be significant reflections of the participants' perceptions (Luborsky, 1994). An effective
33 code is one which identifies important 'moments' and reflects the “qualitative richness”
34 (Fereday & Muir-Cochrane, 2006, p.4) of the phenomenon in question. These pieces of data
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3 are given a definition or a description (Boyatzis, 1998). Codes were linked directly to the data
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5 rather than to extant theories or the researcher's preconceptions (Braun & Clarke, 2006).

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7 Coding entails the categorisation of identifiable topics under headings indicating similarities
8
9 between quotes. The topics are then named to reflect the information they contained
10
11 (Huberman, 1994). For example, the quote "My mother is already used to the environment.
12
13 She agreed to come because she knows I am unable to care for her" was coded under the
14
15 topic "Acceptance of transition to LTC". The data was coded exhaustively. If found to
16
17 encompass more than one idea, the quotes were included under multiple codes.
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21 At stage two, the codes were analysed for conceptual similarities and overlaps. The
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23 first author categorised them into 'sub-themes', or clusters of related codes conveying
24
25 corresponding meaning (Chang, Schneider & Sessanna, 2011). The codes and the sub-
26
27 themes were reviewed for accuracy and relevance.
28

29
30 In stage three, the sub-themes were further refined and integrated into wider
31
32 overarching themes. A theme is "a pattern of information that minimally describes and
33
34 organises the possible observations and at maximum interprets aspects of the phenomenon"
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36 (Boyatzis, 1998, p. 161). These identified themes, derived through repeated, strict adherence
37
38 to and careful reading of the raw data, then become the categories for analysis. The codes are
39
40 then organised into a coherent and meaningful structure, and collapsed together into wider
41
42 categories with corresponding meanings to form themes. The resultant themes were then
43
44 further refined (e.g. those with insufficient supporting data may be discarded, other themes
45
46 combined, or overly complex themes may be further divided).
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50 **Validation.** Each step of the thematic analysis was validated to ensure the credibility
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52 of the data (Bradley, 1993). Exhaustive coding ensures rigour in the analysis (Yardley, 2000).
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54 To further ensure transparency and coherence (Yardley, 2000), the entire process of analysis
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56 was reviewed by an independent researcher, unfamiliar with the raw data but competent in
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3 thematic analysis. The independent researcher confirmed the validity of the analysis,
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5 indicating that the observations could be replicated (Stiles, 1993). The first author and the
6
7 independent researcher discussed the clustering of the codes into themes and sub-themes
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9 (Chang, Schneider & Sessanna, 2011; Stiles, 1993) until 100 percent agreement was reached
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11 (Butcher, *et al.* 2001).
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14 Finally, one third of the transcripts were randomly selected and reviewed as a whole.
15
16 The first and second authors read these transcripts independently, ensuring that the themes
17
18 identified were evident in the original text.
19

20 21 Results

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23 The analysis led to the generation of five themes. Table 2 presents a summary of the
24
25 themes and component sub-themes.
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27 < Insert Table 2 about here >
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29 30 **1. Filial and Cultural Expectations shape caregivers' experience of pre-placement** 31 32 **decisions and post-placement interactions**

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34 As the transcripts were analysed, the importance of filial piety as an important
35
36 framework upon which the participants drew meaning throughout the placement process was
37
38 evident. It was the basis upon which participants made decisions. Filial piety was a set of
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40 expectations shared by both the participants as well as the residents.
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43 Participants constantly re-evaluated role requirements to match their new realities and
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45 held different ways of fulfilling these expectations. They responded by doing more for the
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47 care recipient, thereby fulfilling the filial role in line with the care recipient's and society's
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49 expectations as the participant perceived it. While placement was generally seen as an
50
51 unwelcomed eventuality, participants attempted to fulfil their obligations in other ways. For
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53 example, Participant 10 reviewed her entire time of caregiving for her mother-in-law, and felt
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55 that she had sufficiently fulfilled her caregiving commitment. She said:
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3 "We feel so uncomfortable that we were not given a chance to look after her. But it is
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5 also very lucky that I looked after her for a certain period of time. I have done my part
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7 for that period of time. At least if at that period of time I do not even look after her, I
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9 would feel damn bad right now. What am I? Am I a proper human? I did not do my
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11 job as a daughter-in-law.... at least I tried."

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14 Participant 2 reported that if she was well she would care for her mother at the nursing
15
16 home so they could have time together. Although she was unable to provide the care for her
17
18 at home, she carved out additional roles. She explained, "I will top up all her needs... If I
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20 can't go, if I have flu, I will call and check. If she's sick I will ask (staff) to (consult) the
21
22 house doctor."

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25 For the participants, caregiving was an opportunity to demonstrate their love and
26
27 appreciation for the care they had previously received. Reciprocity was a key aspect of the
28
29 decision to provide care for the care recipient. This was evidenced by sentiments such as
30
31 gratitude. Participant 3 said, "She brought us up [alone], I know. Very hard.... I grateful to
32
33 her for everything I have." Such feelings of gratitude and reciprocity reflected the quality of
34
35 caregiver-care recipient relationship. However, this sense of "giving back" persisted even in
36
37 the face of poor relationships with the care recipient. Participant 9 suggested that "I know she
38
39 is not a good mother. But what to do? She [is] my mother". While this highlights the role of
40
41 the relational history between the caregiver and care recipient, it goes beyond just the
42
43 immediate dynamics of the relationship but speaks of a wider sense of duty which the
44
45 participant felt.

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49 Participants were typically appreciative of the opportunity to demonstrate filial roles
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51 and recognised positive personal outcomes. Participant 3 reflected that caring "makes me
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53 positive because when she's around then I can fully show my love for her. I can present
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55 myself as a daughter ... I can't be filial to my father because he's already dead...I thank God
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3 for the time we have together.” Participant 5 said, “I also happy...I’ve done my duty,... I treat
4 her well”. Although participants never felt that they had achieved their ideals, they expressed
5 their filial piety as a process of continued attempts.
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10 It was also an opportunity to execute their duties in accordance to their own stations
11 in the family. Often participants reflected on their position in the family and what this meant
12 in terms of traditional expectations, such as those for the son. Participant 8 shared that “in the
13 family, I a bit higher education (*sic*)... I have to accept this responsibility.... Usually in
14 Chinese [tradition], the big brother have (*sic*) to take care. Since my big brother cannot take
15 care himself, I have to. Take the responsibility to do everything for them.”
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23 Despite how participants interpreted their filial obligations these ideals were reflected
24 by participants regardless of the length of time since placement.
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27 **2. View of the Placement Decision**

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29 Each participant described having mixed feelings about the placement largely owing
30 to the participants’ own sentiments as well as the residents’ reluctance. Many initially felt
31 uncomfortable with the idea of admitting their care recipient into LTC and held some ideals
32 of providing care at home. Participant 10 delayed the placement decision because: “I feel bad
33 she have (*sic*) to pass her old age that way. That’s really sad because I don’t (*sic*) really
34 expect this ending for her”. Participant 5’s mother had asked to be put in a nursing home so
35 as to alleviate some of Participant 5’s difficulties. However, Participant 5 felt she could still
36 manage: “I tell her no, because right now I still can look after you, I still want to carry on.”
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47 The sense of duty was a main motivating factor in wanting to continue caregiving.

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49 The notion of patriarchy is strong and the placement of the care recipient without their
50 permission felt like it was going against an authority figure. As a result, gaining the care
51 recipient’s agreement to the decision was crucial to majority of the participants. Participant
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3 the authority. She made things very difficult". His mother was finally admitted only after she
4
5 had gone into a delirium and there was no longer any other option. Similarly, Participant 6
6
7 felt herself to be in a bind when her father rejected placement. She reported that: "It is
8
9 important that he agreed ... we have to persuade him until he nod (*sic*) his head."

10
11 Eventually, placement came as a relief because of the practical support offered.
12
13 Participant 12 shared "A lot of worries are out of my mind. At least I can go to work only
14
15 thinking about the work... At least I know she is in the good care of the home." She went on
16
17 to elaborate: My thoughts are to do the best for her, whatever is good for her".
18
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20
21 **Delaying placement through personal sacrifice.** Increasingly unable to cope,
22
23 participants opted for institutionalisation as a last resort and only after making significant
24
25 personal sacrifices to keep the care recipient at home for as long as possible. At times the
26
27 practice of filial caregiving came at great personal sacrifice. Participant 7 who had serious
28
29 health issues, talked about using his limited funds to buy medication for his father instead of
30
31 for his own use. He said "I don't take my medicine, I give it to him."
32
33

34
35 Participants experienced a sense of resignation regarding the placement decision,
36
37 especially when it was suggested by medical professionals. Participant 6 reported that: "We
38
39 just made the decision. It's totally helpless... Mama (has) to go nursing home because the
40
41 doctor (said): discharge her only if she wants to go nursing home... if she doesn't want to go
42
43 to the nursing home then cannot discharge her from the hospital".
44

45
46 **Caregiver's changing ability to care leading to unavoidable placement.**
47
48 Extraneous and caregiver factors presented constraints to continued caregiving at home.
49
50 Participant 3 explained that her own disability prevented caring for her mother: "I cannot
51
52 even bend, squat... That's the reason I cannot bring my mother to stay with me. Because if I
53
54 bring her back, I have to carry her. And the weight I cannot sustain."
55

56
57 Despite reservations most participants saw the placement as something they had to
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1
2
3 accept. Participant 11 said “it was a very clear decision. Although ... we don't like it...there is
4 no other alternative.” He said his mother would “definitely fall. There is no shadow of a
5 doubt, and then she will die faster, and it will be a painful one”.

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9
10 They assessed the care recipient's needs against what they were able to do as
11 caregivers. Participant 6 discussed being unable to cope with the demands of caregiving: “her
12 condition, the tube feeding... because we don't know how to feed her we better don't...
13 danger to her life”. She said, “I cannot cope..., we are not trained....I cannot take too much.”
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Nine participants reported that they wished they were able to provide the care needed but felt
that the best option was formal caregiving in a safer environment.

3. Continued Impact of Caring on the Caregiver

Negative aspects of caregiving. Practically, there was significant concern about
finances and meeting monthly payments following placement. Participant 11 said “[My
sister] has to work. She is the only one that is... fit to work... she has to work... to support my
mother”. Caregiving led to anticipatory anxiety among caregivers. Participant 11 expressed a
sense of ongoing foreboding. She said “I worry about her all the time. What is going to
happen to her?” There was also uncertainty about the future in general Participant 10
expressed, “I do feel frightened too. Nobody can predict what will happen next. Illnesses and
stuff.” Participant 9 said “[I am] 52, how long can I work? Sometimes I sick... [What if] I
pass away? [What happens to my] mother?”

Role Transitions. Role transitions, both pre- and post-placement impacted on
participants' self-image and self-perceptions. Feeling unable to care for her mother impacted
how Participant 3 viewed herself even though the placement decision had occurred 18 years
ago: “I feel I'm very incapable of taking care of her.... my mom can take care of me, how
come I cannot take care of her?” Placement signified a reduction in the caregiving role which
was difficult for the participants to adjust to.

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3 The new role included caring for other family members at home. Participant 4 talked
4 about providing her mother with emotional support after her father was placed in LTC,
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6
7 “Actually, I myself also got this feeling... [but] I need to console her,...how can I do this
8 myself?” Participant 6 had to take on the roles usually performed by her mother prior to her
9 admission and her workload at home increased because she “lost the help of our mother.”
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13
14 Following placement, one new role for the caregiver was as advocate for the resident.
15
16 Many caregivers kept abreast of the care recipient's health and well-being, and of the medical
17 care received. One daughter said of her father who could not communicate, “I will try to talk
18 to my father, then see what is the response. If he feel[s] sick..., but the nurses didn't observe,
19 we will say today... he's got a fever.” Participants were constantly worried that had they not
20 stepped in, the care recipient would have had important needs that were unmet.
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27 **4. Maintaining the Relationship**

28
29 Maintaining the care recipient's personhood extended to the continuity of the
30 relationship. Participants tried various means of maintaining the care recipients' connection
31 to their former lives and identity. Participant 1 said, “occasionally I will bring her home,...
32 Then she's very happy.” He explained “I just want to make her happy that she still got a
33 home.” Participant 10 said, “we... speak to her in our own language... We don't want her to
34 forget [her] own language” Participant 3 explained, “There's a relationship... We don't want
35 them to feel that they are abandoned! We can't look after them, but we can visit them...make
36 them happy.... It's the time and the relationship we have with them.” Participant 3 said, “I will
37 never abandon her. Unless I am dead. I do to my last breath.” Participant 1 shared, “I will
38 come every day,...even tsunami or earthquake I still ... come”. He maintained the sense of
39 togetherness by reassuring his mother at the end of each day that he was returning to his
40 bedroom, instead of telling her that he was going home, so that she did not feel rejected by
41 the move to LTC. As one participant said, “They need the love, we give them, they need the
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3 time we spend with them...I do the best of what I can. So my own conscience—so I don't live
4
5 with regret. If one day she's not around I don't live with regret that I have not been a filial
6
7 daughter.”
8

9
10 Given the care recipient's declining cognitive functioning, the relational bond became
11
12 even more important. Participant 1 shared that his mother no longer remembered his siblings
13
14 “because they don't come so often” and that “she only remembers me. I'm the one closer to
15
16 her.”
17

18 **5. Engagement with the Institution**

19
20 The participants' level of familiarity and comfort with the home was a major
21
22 influence over the amount of comfort they felt at leaving their relative in their care and how
23
24 positively they appraised their placement decision.
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27 **Dealing with the nursing home.** Naturally, the longer the length of the residency, the
28
29 more familiar participants became with the nursing home practices and staff. Participant 3
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31 said that her mother's nurse “is very close to me because my mom stay here nearly 20 years.”
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33 She felt confident that her mother's needs would be met adequately, and that her mother was
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35 at home there. Participants also took efforts to increase this level of familiarity through
36
37 communications with the staff. Through continued engagement, participants hoped for
38
39 improvements in individualised service and care for their relative. However, this was
40
41 disrupted by staff turnover leading to frustration for the caregiver and concern about the
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43 placement decision. Participant 4 said she gets to know the staff at the home and requests
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45 that they “take extra care. Then by understanding they will be able to look into [my father's
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47 needs].” However, at times, this engagement felt like it was driven mostly by the participants'
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49 needs for more knowledge and understanding of the nursing home's practices rather than
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51 something independently offered by home staff as a matter of course. This engagement could
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also have been a reflection of the participants' need to control processes over which they had limited influence.

At times participants felt disempowered when dealing with the home. This sense of disempowerment stems from a perceived lack of reciprocity in information sharing. Most of the participants felt they were not in a position to provide feedback or that it would not be welcomed. Participant 5 said that things were "still the same. Because... the staff keep on changing, and they do not have a proper training... and they don't really stick to the rules." She also feared repercussions for her mother. She said "I cannot [give] feedback... they ask me to do feedback, ...my mom is here".

Even when it came to engagement with the facility, the participants were motivated by their care recipients' needs. The service rendered by the home was as a proxy for the care they were unable to provide themselves, and the facility as a representative of the caregivers in fulfilling their filial duties. As a result, participants attempted to engage with the home more. They regularly expressed a sense of gratitude towards the nursing home. Participant 10 said "I told my [son], we owe the nursing home. They help me to look after your grandmom."

Discussion

This study aimed to explore the experiences and perceptions of Singaporean caregivers spanning the transition process into LTC. Findings revealed important aspects of Asian caregivers' experiences of the transition not previously reported in the literature. The current study presents a unique addition beyond the role of the dyadic relationships in motivating post-placement involvement (Strang et al., 2006). Significantly, this study indicates that filial piety is an added dimension which motivates caregiver involvement and interpretations of the experiences throughout the placement process.

The first theme identified was *Filial and cultural expectations shape caregivers' experience of pre-placement decisions and post-placement interactions*. Filial piety

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2
3 obligations reported by the participants are key to understanding the experience of placing an
4
5 older relative in the home and the caregivers' continued involvement. Filial piety represents
6
7 collectivistic moral duties, attitudes, values and actions of caring for one's elder family
8
9 members. It is founded on reverence and honour for and obedience towards the elder (Zhan,
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11 2004). As such, filial piety strongly influences the way in which Asian caregivers carry out
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13 their roles and is a protective factor in keeping caregivers engaged in the process (Zhan &
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15 Montgomery, 2003). It is a powerful and emotive value that persists throughout the
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17 caregiving process, and includes concern about the elder's health, financial support, housing
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19 and respect for the elders' wishes and authority (Lai, 2010). This is further evidenced by the
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21 participants' suggestion that although they derive satisfaction in being able to provide care,
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23 the process is an ongoing one that persists even after admission of the care recipient. Adding
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25 to previous findings in the literature, such as the importance of filial piety in the placement
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27 decision, the findings from this study indicate that filial piety continues to be relevant after
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29 placement. The current study shows that caregivers, while describing caregiving as difficult,
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31 did not view their role as burdensome. This may be because their caregiving duties were in
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33 line with their values of filial piety. Lai (2010) found that filial piety served a protective role
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35 in reducing the impact of stressors while enhancing the appraisal of caregiving as being
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37 positive and beneficial.
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43 Chang, Schneider and Sessanna's (2011) finding that most Chinese adult children
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45 regard placement as abandonment of the relative was not wholly reflected here. The
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47 caregivers in this study were less exposed to feelings of conflict and ambivalence in making
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49 the decision. Interestingly, this was contrary to Chang, Schneider and Sessanna's report that
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51 despite recognising the necessity of placement, caregivers described feeling torn in their
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53 decision of placement. Instead, current findings suggest that caregivers were better able to
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55 adjust to the decision. While participants strongly endorsed the importance of filial piety,
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3 they were not overly distressed. Rather, they sought proactive means of fulfilling their roles.
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5 The contextual interpretations of filial responsibilities may also reflect changing filial norms,
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7 indicating the caregivers' socialisation to the contemporary environments and demands (Ng,
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9 Philips & Lee, 2002). One complication in gaining a better understanding of filial piety is that
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11 the delivery and receipt of the practice tends to be situationally driven and shaped by social
12
13 and economic circumstances (Ikels, 2004).
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17 The findings from this study echo those based on other Confucian populations. In a
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19 qualitative study of Taiwanese caregivers, Chou, LaMontagne and Hepworth (1999) reported
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21 that filial obligation was inversely correlated to levels of reported burden. This stands in
22
23 contradiction of findings among American caregiving daughters which indicated that
24
25 increased levels of filial obligation were related to increased caregiving burden (Cicarelli,
26
27 1993). This leads to the suggestion that Asian caregivers may be more likely to experience
28
29 higher levels of filial obligation as well as lowered levels of burden due to cultural caregiving
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31 values. However, although the current study was an exploratory effort, it is revealing there
32
33 are some major systematic differences at work. The second theme, *View of the placement*
34
35 *decision*, related to caregivers' interpretations of the placement decision. While there was
36
37 generally a sense of resignation that they had few other viable alternatives in providing care,
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39 the move was also followed by a sense of relief for caregivers. Reluctance to arrive at the
40
41 placement decision was similar to that reported by Grant and Nolan (1993). The decision
42
43 was easier when care recipients acceded to placement. However, in this study, care recipients
44
45 at times agreed to the placement despite their preference for remaining with their families.
46
47 Consistent with findings from other Asian studies, this could be a reflection of how harmony
48
49 and collectivistic values are emphasised (Lee, 1999). The conceptual model postulated by
50
51 Reuss, Dupuis and Whitfield (2005) reflects the above findings. This model suggests that
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53 acceptance of the placement was important to caregivers. This is also paralleled by the
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conceptual order of the placement process suggested by Nolan and colleagues (1996) who state that when both caregiver and care recipient participated in decision making, the experience was deemed to be successful. In this study, it appears that notions of filial piety lead to increased acceptance of placement and their retrospective views of the decision. Additionally, the importance of communal agreement and collectivist good may have contributed to the participants' reflected levels of acceptance. Ironically, while placement may appear superficially as a violation of caregiving obligations, participants did not view LTC as a sign of failure (Lundh, Sandberg & Nolan, 2000). This is a new finding which is in contrast to Chang, Schneider and Sessanna's (2011) report that caregivers continued to feel burdened and distressed by the decision of admission in LTC despite their recognition of the necessity of placement. Engagement with the institution following the placement allowed the participants to evaluate the decision to institutionalise the care recipient. This was consistent with other Asian studies which found that continued evaluation following placement had a strong influence on caregivers' adjustment (Chang & Schneider, 2010). This suggests that increased interactions with LTC staff could serve a positive outcome for caregiver adjustment following placement.

Where Nolan et al (1996) conceptualised Participation in the decision making process and Reuss, Dupuis and Whitfield identified the Control over the Process as the important aspects of the caregiver's involvement, this study found that the need for control persists beyond the initial pre-placement phase into the stage of continued involvement. Caregivers' perceptions of the staff's lack of openness to their inputs and needs was a major factor in how much control the participants felt over the process and their final assessments of the level of person- and relationship-centred care they were receiving (Ryan, Nolan, Reid & Enderby, 2008). This had significant implications for the caregivers' overall satisfaction in dealing with the home and their sense of security for the care recipients' well-being. At times,

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3 participants reflected that communications and cooperation with home staff was insufficient
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5 and unsatisfactory – an assessment which affected their post-move adjustment.
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7 The sub-theme, *Delaying the placement process*, comprises the personal sacrifices
8 and perceptions of coping with care recipients' increased needs as caregivers faced
9
10 deteriorating health and functioning themselves. This theme is consistent with the idea that
11
12 caregivers often feel under-resourced in their roles (Vitaliano *et al.* 1991), as well as having
13
14 to make personal sacrifices to delay placement (Park *et al.*, 2004). In the current study
15
16 participants were often alone in providing care. Previous research indicates that support from
17
18 other family members and professionals, while often felt to be lacking (Ryan & Scullion,
19
20 2000), was crucial in alleviating caregivers' symptoms of depression and improving physical
21
22 health (Sorensen & Pinquart, 2005). In striving to provide care for as long as possible,
23
24 participants endured personal sacrifices of their time. This was in line with findings by Park
25
26 *et al* (2004) among a Korean population of caregiving daughters. The third theme, *Continued*
27
28 *Impact of Caring*, highlighted the agreement among participants regarding the impact of
29
30 caregiving and the role changes experienced as a result of placing their relative in the home
31
32 (Dellasega & Mastrian, 1995). Caregivers undergo significant changes in their role which
33
34 may include taking on the care recipient's areas of responsibility, which ultimately increased
35
36 the caregiver's workload. These changes sometimes caused caregivers to negatively re-
37
38 evaluate their self-image.
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45 Advocating on behalf of the care recipient was another important role that almost all
46
47 the caregivers developed following the transition to LTC. These new roles are consistent with
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49 findings generated from other cultures (Dupuis & Norris, 2001; Stull, Cosbey, Bowman, &
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51 McNutt, 1997). Caregivers in this study were faced with uncertainty of their role following
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53 placement and lacked knowledge regarding how to better assist the care recipient. While
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55 upset by the need for placement, caregivers continued to craft a relevant role for themselves.
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3 This is in contrast to reports that caregivers saw placement as a “caregiving failure”
4
5 (Smallegan, 1985) and caregivers did not relinquish the bond (Ross, Rosenthal & Dawson,
6
7 1993) but rather worked to strengthen it.
8

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10 The fourth theme, *Maintaining the Relationship* often related to the idea of
11
12 maintaining the care recipient’s identity (Bowers, 1987; Hasselkus, 1998), (e.g. using the care
13
14 recipient’s primary language and offering their favourite foods). Additionally, being able to
15
16 continue with key aspects of their pre-placement lives was important to caregivers and gave
17
18 them an opportunity to fulfil roles they perceived as relevant. Such opportunities led to
19
20 increased caregiver satisfaction. The desire to maintain the relationship and continue with
21
22 caregiving roles may also be reflective of the perceived conflict between the caregiver’s
23
24 values and the apparent non-filial act of placing one’s relative into LTC which has been noted
25
26 to cause feelings of ambivalence in other Asian studies (Chang, Schneider, & Sessanna,
27
28 2011). This theme was also consistent with findings in the wider literature following
29
30 placement. This finding reflects the theme of deeply bonded relationships and attempts at
31
32 continuity among caregivers (Strang et al., 2006)
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36
37 One of the key roles played by caregivers post-placement is in maintaining continuity
38
39 for the resident. For LTC facilities, taking a relationship-centred stance may improve the
40
41 involvement and support of family caregivers and of how homes are perceived when it comes
42
43 to making the placement decision. This is in line with Sussman and Dupuis’s (2014) findings
44
45 that interpersonal interactions with family following placement facilitates the residents’
46
47 adjustment to LTC. In extension to Sussman and Dupuis’s findings, staff may also further the
48
49 residents’ and caregivers’ adjustment to the LTC environment by offering relationship-
50
51 centred support.
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54 Overall, while relationship factors as described were crucial, in addition to findings by
55
56 Strang and colleagues (2006), it appears that in the current study, filial obligations were an
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3 added social dimension to the demands and expectations perceived by the caregivers. This
4
5 conjunction of relationship reciprocity and filial obligation is likely to lead to a compulsion
6
7 for continued caregiving.
8

9
10 Caregivers' participation with the home is reflected in the fifth theme, *Engagement*
11
12 *with the Institution*. Over time, participants developed an attachment with the home. Often
13
14 caregivers felt that such a relationship ensured that the care recipient received better service
15
16 and closer attention from the home staff. This extension of the role demonstrates how the
17
18 caregiving role evolves beyond merely being task-based ADLs and includes socio-emotional
19
20 aspects such as in facilitating the development of the relationship between the resident and
21
22 LTC staff. As described by Gaugler (2005), few previous studies have delved into this
23
24 dimension of post-placement caregiving. Caregiver's poor relationships, in particular
25
26 perceived conflicts, with staff increases caregiver depression rates (Chen, Sabir, Zimmerman,
27
28 Suitor, & Pillemer, 2007). Furthermore, lack of perceived support also led to feelings of
29
30 disempowerment for the caregiver. The quality of the relationship with the staff and
31
32 engagement with the home is important because it leads to a sense of disempowerment as
33
34 described by the participants. Furthermore, a poor relationship is likely to lead to increased
35
36 anxiety about the resident's well-being and has been found to lead to decreased family
37
38 visitations (Port, 2004). The sense disengagement with the home and disempowerment is
39
40 reflected as the lack of control. This is important because it affords the caregivers an
41
42 important opportunity to come to terms with the decision made and to maintain ownership of
43
44 the decision. The relationship between LTC staff, caregivers and residents is central to the
45
46 adjustment to placement has been found to increase a sense of satisfaction and positive
47
48 outcomes (Ryan, Nolan, Reid & Enderby, 2008).
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54 Themes four and five were reflective of Sussman and Dupuis's (2014) suggestion that
55
56 the complexity of adjusting to LTC was shaped by multiple dimensions in the transition of
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3 caregiving. In the current study, the interpersonal relationship between the caregiver and
4
5 resident was also influenced by the systemic layer of broader social values and culture – filial
6
7 piety. In order to enhance adjustment, staff need to be aware of how the caregiver and
8
9 resident may experience their duties and what placement may mean to them personally.

11 *Implications*

14 Caregivers require adequate support at key stages throughout the placement transition.
15
16 Prior to contemplating placement, support is needed in terms of dealing with care recipient
17
18 behaviours. Appropriate caregiver training may address issues of feeling under resourced
19
20 when performing ADL such as feeding and bathing. During the decision making phase,
21
22 support is necessary in terms of explaining the rationale for placement, as well as managing
23
24 care recipient responses. Following placement, the institution may increase opportunities to
25
26 engage caregivers. The caregiver's sense of disempowerment or loss of a major role may be
27
28 countered with preparation for what may be expected. As suggested by Sussman and Dupuis
29
30 (2014), at the systemic layer, LTC staff may recognise the role of interpersonal interactions
31
32 and the importance of filial piety. LTC facilities may offer ways in which caregivers may
33
34 continue with key roles and activities of the pre-placement phase to facilitate their and the
35
36 care recipients' adjustment. Commending and providing opportunities for caregivers to
37
38 continue with routine caregiving activities may facilitate adjustment for both the resident and
39
40 the caregiver, and may alleviate the sense of failing one's filial duties. In treating caregivers
41
42 as part of the team, and by drawing from their knowledge and expertise on the resident, staff
43
44 may increase the caregiver's confidence and comfort in the placement decision as well as
45
46 increase their post-placement involvement.

51 *Strengths and Limitations*

54 Given the participants' awareness of the study's objectives, it is possible that they
55
56 may have been responding in a manner perceived to be socially appropriate. Nonetheless, this
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2
3 is a common issue in caregiver research. Furthermore, participants' regular visits,
4
5 maintenance of their relationship and the continued involvement in the care recipient's care
6
7 corroborates their self-report.
8

9
10 While adequately reflecting the view of caregivers who chose to remain involved in
11
12 their older relatives' lives, the findings from this study do not capture a significant and
13
14 important subset of the population. As reflected by anecdotal reports from the nursing home
15
16 staff, a significant proportion of families were less involved with their family member than
17
18 the participants of this study. Nonetheless, this data provides an opportunity to understand
19
20 perceptions of family members who continued to care for their relatives after they have been
21
22 placed into LTC.
23

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25 This study overlooks the multi-phased nature (Sussman & Dupuis, 2012) of the
26
27 placement process and reviews caregiver experiences from a retrospective angle. The
28
29 differing amounts of time since the participants went through the placement process may alter
30
31 their recall of the experiences. However, we believe that the findings here are still pertinent,
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33 especially given the high rate of agreement among the participants, since they add to the
34
35 literature about caregiver sentiments at the present time.
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39 The findings arising from this study are enriched by the qualitative approach which
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41 allows for the caregiver's personal meaning of the experience to be understood. Future
42
43 studies may take a longitudinal approach and assess how caregiver's experiences change over
44
45 time through the course of caregiving. Further understanding is also needed to comprehend
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47 the unique factors that Singaporean caregivers may face as well as to explore the role of the
48
49 relationship and culture in caregiving decisions.
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51 52 **Future research**

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54 A quantitative investigation is needed in order to understand the Singaporean
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56 caregiver's appraisal of filial piety, burden and how these factors affect their caregiving
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3 outcomes. Furthermore, previous research indicates that social support and coping styles are
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5 the core factors which distinguishes between cultural groups. Further understanding of how
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7 caregiver values, coping styles and social support mechanisms operate in a collectivist
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9 society is necessary.
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11 **Conclusion**

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14 This study aimed to understand the Singaporean caregivers' experiences and
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16 perceptions regarding the placement of an older care recipient into LTC. Cultural values were
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18 found to significantly impact on the caregiving experience. Caregivers placed significant
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20 emphasis on filial piety which seemed to impact on their caregiving role prior to placement,
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22 when making the decision to place their relative into LTC and after placement. Whilst
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24 placing a relative into care changed the nature of the caregiving role, it was still fraught with
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26 difficulties. Caregivers worked hard to maintain their close relationship with their relatives in
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28 LTC whilst also building a new relationship with the facility.
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Table 1. Participant profiles.

Participant number	Relationship to Resident	Sex	Age	Employment status	Care Recipient's Age & Gender	Length of Residence in LTC	Primary reasons cited for placement
1	Son	Male	55	Part-time	84, Female	4.5 years	Unable to care
2	Daughter	Female	63	Unemployed	84, Female	2 months	Unable to care
3	Daughter	Female	54	Part-time	77, Female	18 years	Unable to care
4	Daughter	Female	38	Full-Time	71, Male	1 year	Unable to care
5	Daughter	Female	51	Full-Time	78, Female	2.5 years	Unable to care
6	Daughter	Female	40	Part-time	73, Male /74, Female	3.5 years/ 3 years	Unable to care

(Table 1 continues)

CAREGIVERS' EXPERIENCES OF INSTITUTIONALISATION

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(Table 1 continued)

Participant number	Relationship to Care recipient	Sex	Age	Employment	Care Recipient's Age & Gender	Length of Residence in LTC	Reasons cited for placement
7	Son	Male	52	Part-time	82, Male	5 years	Relationship factors
8	Brother	Male	59	Full-Time	64, Male	2.5 years	Unable to care
9	Daughter-in-law	Female	46	Unemployed	70, Female	2 years	Unable to care
10	Son	Male	51	Full-Time	71, Male	3 months	Unable to care
11	Son	Male	70	Unemployed	100, Female	7 months	Unable to care
12	Daughter	Female	65	Part-time	100, Female	10 months	Unable to care

CAREGIVERS' EXPERIENCES OF INSTITUTIONALISATION

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Table 2. *Summary of Codes, Themes and Sub-Themes*

Themes	Sub-Themes	No. of participants endorsing
Filial and Cultural expectations shape caregivers' experience		12
View of the placement decision	Delaying placement through personal sacrifice	12
	Caregivers' changing ability to care leading to unavoidable placement	12
Continued Impact of caring	Caregiver's shifting role	12
	Difficulties in providing care	12
Engagement with the institution	Dealing with the home	11
	Perceptions of nursing homes	9
Maintaining the relationship	Continuity of the relationship	11
	Concerns for the relationship	12
	Protecting the care recipient	12
	Caregiver's continued involvement	11

Statement of Ethical Approval:

Ethical approval for this project was granted by the James Cook University Human Research Ethics Committee (Application Id: H4219D).

Statement of funding:

No external funds were received for the conduct of this project.

Statement of conflict of interests:

There are no known conflicts of interests which arose in the conduct of this research paper.

Declaration of the contribution of authors:

Rajini Ramanathan and Dr. Paul Fisher contributed towards the (a) the conception and design, analysis and interpretation or validation of the data; (b) the drafting of the article or revising it critically for important intellectual content and (c) approval of the version to be published.

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