Are Expectations for Care Related to the Receipt of Care? An Analysis of Parent Care Among Disabled Elders

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This investigation explores the relationship between the degree to which older parents expect assistance from their children and the actual amount of care they receive from their children. Combining the theories of reasoned action and intergenerational solidarity, we hypothesize that global expectations (social norms about receiving care) influence specific expectations (behavioral intentions to seek care), but that it is specific expectations that influence the amount of care received from children. Data were collected at three points over a 12-month period among a sample of impaired older parents (65+) who lived independently in community settings (n = 334). Using structural equation models, the results were consistent with the hypothesis. We conclude that the theory of reasoned action is a useful adjunct to the theory of intergenerational solidarity by proposing that parents adjust their global expectations to reflect the specific realities of the lives of their children.

Adult children are a critical source of aid and assistance to older parents. Previous research has demonstrated that adult children provide substantial assistance with a wide variety of tasks and often over extended periods of time (Brody & Schoonover, 1986; Coward & Dwyer, 1990; Hamon & Bleszner, 1990; Horowitz, 1985; Montgomery, 1992; Spitz & Logan, 1990; Stoller, 1983; Stoller & Earl, 1983). This assistance is widely considered normative—that is, aging parents expect assistance from their adult children, and adult children expect to help their aging parents (Brody, Johnson, & Fulcomer, 1984; Hanson, Sauer, & Seelbach, 1983; Lee, Netzer, & Coward, 1994a, 1994b, 1995; Schorr, 1960; Seelbach, 1977, 1978, 1984; Seelbach & Sauer, 1977). Expectations regarding such assistance have been termed norms of filial responsibility (Seelbach, 1977).

Previous research has identified considerable variation in the degree to which norms of filial responsibility are endorsed across various segments of the population. For example, most studies have found that “older persons are slightly less supportive of filial responsibility norms than are younger persons” (Lee et al., 1994b, p. 101). This finding stands in contrast to the instrumental reality that older persons tend to be the beneficiaries of filial responsibility, whereas younger persons typically sustain the costs. There is also evidence of variation across groups of elders. Older women, those with lower incomes, and those in poorer health are more likely than other older persons to endorse filial responsibility norms (Lee et al., 1994b; Seelbach, 1977, 1978).

In Bengtson’s theory of intergenerational solidarity (Bengtson & Harootyan, 1994; Bengtson, Olander, & Hadad, 1976; Bengtson & Roberts, 1991), filial responsibility norms may be classified as a dimension of normative solidarity, which refers to social norms that emphasize the importance of family relations, and assistance provided by adult children to parents as a dimension of functional solidarity, or the exchange of assistance between generations (Lee et al., 1994a). Although various dimensions of intergenerational solidarity may be empirically independent, previous studies have found some indications that the endorsement of norms of filial responsibility by adult children is positively related to their provision of instrumental support to parents, at least in some circumstances (Silverstein & Litwak, 1993; Silverstein, Parrott, & Bengtson, 1996). There is no evidence, however, that the filial responsibility norms of older parents are related to their receipt of support from children. In fact, Lee et al. (1994a) found that the filial responsibility expectations of parents were unrelated to the amount of assistance the parents received from their children but were positively associated with the extent to which aged parents provided assistance to their adult children. This suggests that some parents may expect more assistance from children than they receive, potentially leading to disappointment and strained family relations.

To account for the absence of a relationship between their measure of the filial responsibility expectations of parents and the receipt of care from children, Lee and his associates (1994a) suggested that parents may modify their global expectations about the obligations of adult children...
based on the specific circumstances of their children’s lives. An older person may, in general, feel strongly that adult children are obligated to help parents in old age but understand that specific obstacles prevent their children from providing the assistance they need. For example, raising children, marital conflict, or lack of employment may limit the resources that adult children can devote to caring for elderly parents.

The capacity of older parents to adjust their expectations of their children is entirely consistent with a distinction made by the theory of reasoned action (Azjen, 1985; Azjen & Fishbein, 1980; Blue, 1995; Fishbein & Azjen, 1975; Sheppard, Hartwick, & Warshaw, 1988). This conceptual framework links general social norms to actual social behavior through an intervening mechanism, behavioral intentions. General social norms are one of many influences on the behavioral intentions of an individual (i.e., what an individual intends to do when faced with a specific problem), but it is specific behavioral intentions that are associated with actual behaviors. Accordingly, parents may endorse generalized social norms that children are obligated to care for aging parents who are in need. However, when faced with such a need themselves, parents may intend to turn elsewhere for aid and assistance—either because of their own personal circumstances (e.g., they can afford to purchase care rather than burden their children) or because of the specific circumstances or limitations in the resources of their children.

The purpose of this investigation is to examine the effects of both the global (social norms) and specific (behavioral intentions) expectations of elderly parents about the receipt of care from adult children on their actual experiences of receiving aid and assistance. Because global measures of filial responsibility expectations fail to take into account the specific life circumstances and resources of the children of older adults, we anticipate that a model that includes a measure of specific expectations will more accurately reflect observed patterns of care from children. A sample of older (65+) disabled parents living in community settings is used to examine these issues.

METHODS

The Sample for This Investigation

The respondents for this analysis are participants in a longitudinal study examining race and residence differences in the long-term care patterns of older adults. Data collection began in the Spring of 1993 and concluded in the Fall of 1996. In this investigation, we focus on a subset of 334 respondents from the full panel (n = 1,200), who are parents with difficulties performing everyday activities of daily living. The sample for the main study (n = 1,200) was selected from community-dwelling older respondents (65+) residing in four counties in northern Florida and was constructed using a two-stage disproportionate sampling approach (Aday, 1989). The purpose of the first stage of sampling was to complete a telephone screening (using both random digit dialing and commercial age-targeted telephone lists) of four selected counties to identify a pool of older respondents who would agree to participate in follow-up telephone interviews (n = 5,254). Using a standard computation technique for telephone surveys (Luck & Rubin, 1987), a cooperation rate of 74.4% was obtained during the screening stage. The second stage of the sampling was designed to recruit a stratified random sample of 1,200 older residents from the screened pool to engage in longer, more detailed, repeated telephone interviews. The panel of respondents was stratified by race (African American/White), place of residence (rural/urban), income (above poverty/poverty), and health (disabled, partially disabled, and not disabled). For more details on the sampling techniques that were employed, see Coward et al. (1997) and Gilbert, Duncan, Kulley, Coward, and Heft (1997).

Following the baseline interview in Spring 1994, telephone interviews have been conducted with the panel at 6-month intervals. The follow-up interviews have focused on the health of the elders at the point of reconnect and determined any changes that occurred in their ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), in their receipt of assistance from either formal or informal sources of care with ADLs or IADLs, or in the composition of their households. The total number of interviews completed at each of the data collection points were: Spring 1994 = 1,200; Fall 1994 = 1,065; Spring 1995 = 1,005; Fall 1995 = 957; and Spring 1996 = 906. Panel-to-panel response rates have averaged 89.4%. Where attrition has occurred, it is more likely the result of death, entrance into a nursing home, or illness that prohibited continued participation (n = 149), rather than refusal to continue to participate (n = 110).

In that the focus of this investigation is on parental filial expectations, we concentrate on three waves of data collection beginning with the Spring 1995 interviews, when respondents were queried about their expectations for care, and for two subsequent 6-month intervals (Fall 1995 and Spring 1996). Because we wanted to examine the effects of expectations on the amount of care received from children, and care received can be episodic (i.e., parents experiencing functional limitations may be receiving care at one point and not at another), we focus on the amount of care received from children at all three data points to account for instances of episodic care. All other measures for the multivariate analysis are taken from the Spring 1995 interviews or earlier points in the study.

From the respondents who completed the Spring 1995 interviews (n = 1,005), we excluded from this analysis older respondents who did not have any children (n = 266). From the remaining 739 parents, we limited the sample further by excluding those parents who reported no difficulties performing ADLs or IADLs in the Spring of 1995 or in either of the two subsequent interviews (Fall 1995 or Spring 1996) (n = 327). These parents were excluded because our focus was on the amount of care received from children with ADL and IADL tasks. Because these parents reported no difficulties in performing such tasks by themselves, by default they could not have received care from their children as defined in this study (i.e., only those respondents who reported difficulty performing tasks were asked who helped them). Their inclusion, therefore, would have resulted in a nested effect, because everyone without...
an ADL or IADL impairment would also automatically have been in the category of parents not receiving care from their children.

Of the 412 parents who reported difficulties performing ADL and IADL tasks (and thus who were eligible for this investigation), 334 (81.1%) were included in the final sample. Among those excluded, 33 were eliminated because of item-specific nonresponse, and 6 were removed because they had residence changes but it was unclear whether their urban or rural status had changed. An additional 39 respondents were not included because they had not participated either in the Fall 1995 or the Spring 1996 round of interviews. Among these, the primary source of attrition was death, entrance into a nursing home, or an illness that prohibited continued participation (n = 20), rather than refusal to continue to participate (n = 8). The other 11 respondents remained active in the study, but had missed one of the rounds of interviews on which we focused. Analyses revealed that there were two significant differences between the sample of parents with ADL and IADL impairments that were excluded (n = 78) and those parents with such disabilities that were in the final sample (n = 334). The respondents who were not included in the analysis had a higher percentage of men (32.1% vs 19.8%) and elders who had no expectations for their children to help them (51.3% vs 25.2%).

Thus, the final sample used in this analysis consists of 334 respondents and is comprised mostly of women (80.2%) and individuals who were not married (69.5%, the predominant proportion of whom were widowed). Race and residence distributions are relatively equal because of the stratification of the sample on these variables, with 51.8% of the sample African Americans, and 56.2% of the respondents living in rural as opposed to more urban and suburban areas. The average age of respondents in Spring 1995 was 76.0 years (standard deviation = 6.3), and the mean number of children was 3.5 (standard deviation = 2.6). With respect to health characteristics, 45.3% of the sample had at least one ADL limitation in Spring 1995, whereas 86.5% had at least one ADL in any of the three time periods. Also in Spring 1995, 38.5% of the sample had at least one IADL limitation, and 72.6% reported difficulty performing at least one IADL over the three time periods. Finally, 74.9% of the sample reported that they expected to turn to their children for help, whereas 31.7% actually received help with ADLs or IADLs from their children during the 1-year period of observation.

Measures

**Amount of care received from children.**—The dependent variable in this analysis is an indicator of the amount of care that disabled parents receive from their adult children. To construct this continuous indicator, we summed responses to a series of questions determining who helped the elderly parent with six ADLs (i.e., bathing, dressing, eating, transferring, walking, and toileting) and four IADL tasks (i.e., getting to places outside of walking distance, shopping for groceries and personal items, doing light housework, and preparing meals) across a 1-year period of time or three separate data collection points (Table 1 contains a list of the dependent variable and the other model variables used in this investigation and indicates the interview wave in which they were measured). For each task, the receipt of care from adult children is coded “1” (children includes sons, daughters, sons-in-law, daughters-in-law, and any combination thereof), whereas “0” represents no care received from a child. If more than one child helped with the same task, the variable was still coded as a “1.” Thus, the theoretical range of the dependent variable is 0 (i.e., no help from children with any of the tasks at any of the three data collection points) to 30 (indicating help from children with all the 10 tasks at all three data collection points). However, the actual range of the dependent variable in this sample is 0 to 9. The mean for the dependent variable was .9 (standard deviation = 1.8).

**Filial responsibility expectations.**—The primary independent variables are global and specific filial responsibility expectations and were both measured in the Spring 1995 interview. Global expectations or social norms about older parent–child relationships were measured by the degree to which respondents agreed with six statements about the relationship between adult children and their elderly parents (a 4-point scale ranging from strongly disagree to strongly agree). These statements were adopted from Lee et al. (1994a) and included: (1) as many activities as possible should be shared by grown children and their parents; (2) if children live nearby after they’ve grown up, they should visit their parents at least once a week; (3) grown married children should live close to their parents so that they can help each other; (4) a family should be willing to sacrifice some of the things they want for their children in order to help support their aging parents; (5) older people should be able to depend on their grown children to help them do the things they need to do; and (6) parents are entitled to some return for the sacrifice they have made for their children. Factor analyses indicated that the first and second items loaded onto a separate factor, and they were dropped from further analysis. The final factor is a summary measure and contains four questions (Cronbach’s alpha = .8; range 1–6; mean 1–10; standard deviation = 2.8).

To represent the specific expectations of the elders, we asked the respondents who they intended to seek help from if they encountered four circumscribed problems. To our knowledge, there are no existing measures of specific expectations in the literature; thus, we could not employ an established instrument. Therefore, in order to operationalize this concept in the theory, we decided to ask respondents to react to four scenarios that are commonly faced by older adults. Specifically, we asked the respondents to indicate who they would turn to if: (1) they felt lonely and needed to talk (45.2% of the sample volunteered that they would turn to a child); (2) they needed help getting to the doctor (49.4% of the sample would ask a child for help); (3) they found out that they did not have enough money to pay a big medical bill (31.7% would turn to child for help); and (4) if they found that they could no longer live on their own because of failing health, where they would live (28.4% indicated they would live with a child).

This measure was coded such that if the respondents in-
Table 1. Description of Variables Included in the Investigation

<table>
<thead>
<tr>
<th>Variable Measured</th>
<th>Description</th>
<th>Coding</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of care received from children</td>
<td>Self-reported receipt of help from children with 6 ADL and 4 IADL tasks at three different points in time</td>
<td>Continuous variable: range 0-30</td>
<td>Spring 1995, Fall 1995, Spring 1996</td>
</tr>
<tr>
<td>Global filial responsibility expectations</td>
<td>Respondent indicates his or her level of agreement with four statements describing social norms about interaction with children (1 = strongly disagree; 2 = disagree; 3 = agree; and 4 = strongly agree)</td>
<td>Continuous variable: range 1-16</td>
<td>Spring 1995</td>
</tr>
<tr>
<td>Specific filial responsibility expectations</td>
<td>Open-ended questions about who respondent would turn to for care if he or she encountered four circumscribed problems</td>
<td>Dichotomous variable: 1 = child named as source of care in at least one of the problem areas; 0 = no children named as sources of care</td>
<td>Spring 1995</td>
</tr>
<tr>
<td>Race</td>
<td>Self-reported race of respondent</td>
<td>Dichotomous variable: 1 = African American; 0 = White</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender of respondent</td>
<td>Dichotomous variable: 1 = female; 0 = male</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Marital status</td>
<td>Marital status of respondent</td>
<td>Dichotomous variable: 1 = married; 0 = not married (divorced, widowed, separated, or never married)</td>
<td>Spring 1995</td>
</tr>
<tr>
<td>Age</td>
<td>Self-reported age of respondent in years</td>
<td>Continuous variable: range 65-97</td>
<td>Spring 1995</td>
</tr>
<tr>
<td>Residence</td>
<td>Place of residence</td>
<td>Dichotomous variable: 1 = rural; 0 = urban</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Education</td>
<td>Educational attainment of respondent</td>
<td>Ordinal measure: range from less than a high school degree to post-college graduate work (higher scores indicating more education)</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Number of children</td>
<td>Count of children</td>
<td>Continuous variable: range 1-15</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Proximity of children</td>
<td>Indicator of any children living within 10 miles of elder parent</td>
<td>Dichotomous variable: 1 = presence of a proximate child; 0 = no children living within 10 miles of parent</td>
<td>Spring 1994</td>
</tr>
<tr>
<td>Number of IADLs</td>
<td>Self-reported number of 4 IADLs performed with difficulty</td>
<td>Continuous variable: range 0-4</td>
<td>Spring 1995</td>
</tr>
<tr>
<td>Number of ADLs</td>
<td>Self-reported number of 6 ADLs performed with difficulty</td>
<td>Continuous variable: range 0-6</td>
<td>Spring 1995</td>
</tr>
</tbody>
</table>

dicated that they would turn to a child under any of the scenarios, the variable was coded as "1" (74.9% of the sample indicated that they would turn to a child for help with at least one of the scenarios). If the respondents indicated that they would turn to sources of care other than a child for all four questions, they were given a code of "0." We explored coding this variable as a continuous measure (range 0-4); however, the results from a multivariate analysis indicated that the relationship was not linear. That is, the significant difference was between the respondents in the sample who did not name children as potential helpers in any of the scenarios and the rest of the sample who named a child under one circumstance or another.

Because the interviews conducted in the Spring of 1995 measured both expectations for care from children (global and specific) and the amount of care received from children, we were concerned about the temporal confounding of these factors. To explore this possibility, we examined the relationship between expectations for care and receipt of care in two distinct samples of parents. The first sample included both respondents who were and who were not receiving care from children in Spring 1995 (n = 334). The second sample excluded those respondents who were receiving care in Spring 1995, and focused only on those who were not receiving care at the initial point of observation (n = 285). The restrictions imposed on the latter sample avoided the possible confounding effect of measuring expectations for care and the receipt of care in the same time period. A comparison of the ordinary least-squares regression coefficients using a t test (where amount of care received from children was regressed separately on specific expectations and global expectations for each of the two groups) indicated that the association between specific and global expectations for care and the amount of care received from children did not vary significantly across the two groups of respondents (specific expectations t score = 1.8; global expectations t score = .5). Therefore, because there was no statistically significant difference between the effect of expectations on care received among the two groups, they were pooled.
**Need and availability characteristics.**—In order to assess accurately the relationships between global and specific expectations and the amount of care received from children, other variables that are potentially correlated with them must be controlled. For example, both the parents' need for care and the availability of potential child caregivers likely influence the amount of care received by children. Parents' need for care was assessed by the number of ADL and IADL tasks that they performed with difficulty at the initial point of observation in this study (i.e., Spring 1995). Separate scales were constructed for ADLs (range = 0–6; mean = .8; standard deviation = 1.1) and IADLs (range = 0–4; mean = .8; standard deviation = 1.2).

We also measured the availability of children as potential caregivers. Proximity, for example, is one factor that may facilitate or limit the caregiving behaviors of an adult child. Certain types of instrumental help (such as providing financial assistance or giving advice) may be given from a distance, but the types of assistance that we address in this investigation (help with ADLs and IADLs) can be given only if children live nearby. In this investigation, proximity is a dichotomous measure indicating whether the elderly parent had any children living within 10 miles in the Spring of 1994 (56.6% had proximate children). Another factor affecting the availability of children as potential caregivers is the total number of children. For instance, greater numbers of children may increase the likelihood of receipt of care, because parents may be able to ask more than one child for help.

A number of other sociodemographic factors influence the provision of parent care. For example, some studies indicate that women and older African Americans are more likely to receive help from their children than are men and older Whites (Burton, Kasper, Shore et al., 1995; Himes, Taylor, & Chatters, 1991). To control for these other influences, we include measures of gender, race, place of residence, marital status, age, and education (Abramowitz, 1988; Burton et al., 1995; Dwyer & Coward, 1991, 1992; Montgomery, 1992; Peek, Coward, Henretta, & Duncan, 1997). The race of all respondents is self-reported as Black or White. Place of residence is classified as rural or urban. The urban sample was selected from the downtown sections of a single city in northern Florida (population in 1990 of 635,230), and the rural sample came from three nonmetropolitan counties that were located in the same region of the state, but with much smaller and more dispersed populations (the 1990 populations of the three nonmetropolitan counties ranged from 10,930 to 16,569 people). Marital status was measured as married versus not married (the latter including the divorced, widowed, separated, and never married), whereas age was treated as a continuous variable measured in years. Finally, education was an ordinal measure ranging from less than a high school degree to postcollege graduate work (higher scores indicating more education).

**Analysis**

In order to assess both the direct and indirect effects of global and specific expectations, we use structural equation models estimated with LISREL 8.12 (Joreskog & Sorbom, 1993). Structural equation models are sets of techniques that permit causal analysis, as well as the treatment of measurement error and latent constructs, the estimation of direct and indirect effects, and the specification of error and error correlations (Alwin, 1988). Following the logic of the theory of reasoned action, the primary hypotheses are: (1) global expectations will have a direct effect on specific expectations but not on the amount of care received from children; (2) specific filial expectations will have a direct effect on the amount of care received from children; and (3) global expectations will have an indirect effect on the amount of care received from children through their direct effect on specific expectations. Though we do not stipulate specific hypotheses regarding the effects of the sociodemographic, need, and availability factors of older adults on their specific and global expectations for care from children or on the amount of care they received from children, past research has suggested that these characteristics influence both the attitudes of older adults about the receipt of care (Lee et al., 1994a) and their actual receipt of care from children (e.g., Dwyer & Coward, 1991; Montgomery, 1992; Spitze & Logan, 1990; Stoller & Earl, 1983). Thus, we will account for the effects of these independent variables in the statistical models.

**Estimation.**—The coefficients for the LISREL models are weighted least squares based on matrices provided by PRELIS. Weighted least squares are used instead of maximum likelihood or generalized least squares because of the presence of both discrete and continuous measures in the data (Joreskog & Sorbom, 1993). PRELIS is used to generate a matrix of polychoric correlations and an accompanying matrix of asymptotic variances and covariances. With these matrices as input, the structural equation models are estimated using the weighted least-squares fitting function in LISREL 8.12, which is asymptotically distribution free (Joreskog & Sorbom, 1993). Because all constructs have only one indicator, no measurement model will be discussed.

**Results**

Table 2 contains the correlation matrix for all model variables. At the bivariate level, specific expectations are significantly correlated with the amount of help received from children. Global expectations are positively correlated with the presence of both discrete and continuous measures in the data (Joreskog & Sorbom, 1993). Here, a statistically significant correlation (p < .07). As expected, however, global expectations and specific expectations are significantly associated. Gender, marital status, education, number of children, and physical health limitations are all significantly correlated with the amount of care received from children. Women, elders who were not married, those with less education, those with more children, and those with more ADL and IADL limitations all received greater amounts of care from children.

**Direct and Indirect Effects of Model Variables**

Table 3 presents the standardized structural parameter estimates for predicting the effects of both global and specific filial responsibility expectations on the amount of care received from children. This table includes the direct effects
of sociodemographic, need, and availability factors on both types of expectations as well as the direct effects on the amount of care received from children.

The LISREL analysis indicates that there is empirical support for each of the three hypotheses. First, global expectations were observed to significantly and positively influence the specific expectations of parents regarding the amount of care they received from their children \((b = .11, p < .01)\). Second, there was a significant positive influence of specific expectations on the amount of care received from children \((b = .18, p < .01)\). Third, there was no significant direct effect of global expectations on the amount of care received from children. However, there was a positive significant indirect effect of global expectations on the amount of care received from children \((b = .02, p < .01)\). Thus, there is support for the proposition that social norms (i.e., global expectations) have no direct effect on the amount of care received from children, but do have a direct influence on behavioral intentions (i.e., specific expectations), which then affect the amount of care received from children. The relatively good fit of the model summarized in Table 3 to the data (i.e., the root-mean-square error of approximation [RMSEA] is .08, and the adjusted goodness-of-fit index [AGFI] is .97) suggests a reasonable approximation of the model in the sample.

Several other variables in the model have significant direct effects on the amount of care received from children. For example, the number of IADL limitations has a significant positive effect on the amount of care received. This finding is consistent with previous research that indicates that those in greater need receive more care (Lee et al., 1995). However, living in a rural area and having an increased number of ADL limitations are negatively associated with the amount of care received from children. The negative effect of residing in sparsely populated and geographically remote rural settings may be a result of adult children being less proximate due to education and employment migration patterns (Lee, Dwyer, & Coward, 1990). and, as a consequence, having fewer direct interactions with their elderly parents (Coward, Lee, & Dwyer, 1993). With respect to the negative effect of number of ADLs on the amount of care received from children, it may be that the intimacy of ADL tasks inhibits the participation of children due to norms of privacy and incest (Montgomery, 1992). That is, older parents may feel more comfortable receiving care with these tasks from spouses (if they are available) or even from formal care providers rather than their children.

### Table 2. Correlation Matrix of Model Variables \((n = 334)\)

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Global expectations</th>
<th>Specific expectations</th>
<th>Amount of care received from children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of IADLs</td>
<td>.35*</td>
<td>.08</td>
<td>.04</td>
</tr>
<tr>
<td>Number of ADLs</td>
<td>.35*</td>
<td>.08</td>
<td>.04</td>
</tr>
<tr>
<td>HDL</td>
<td>.35*</td>
<td>.08</td>
<td>.04</td>
</tr>
<tr>
<td>Age</td>
<td>.29+</td>
<td>.15+</td>
<td>.01</td>
</tr>
<tr>
<td>Rural</td>
<td>.29+</td>
<td>.15+</td>
<td>.01</td>
</tr>
<tr>
<td>Black</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>Number of children</td>
<td>.35*</td>
<td>.08</td>
<td>.04</td>
</tr>
<tr>
<td>Number of children</td>
<td>.35*</td>
<td>.08</td>
<td>.04</td>
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<td>HDL</td>
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<td>Age</td>
<td>.29+</td>
<td>.15+</td>
<td>.01</td>
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<tr>
<td>Rural</td>
<td>.29+</td>
<td>.15+</td>
<td>.01</td>
</tr>
<tr>
<td>Black</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
</tbody>
</table>

*Estimates with standardized weighted least squares; \(\_\_\) parameter not included in the equation; ns, coefficient not significant at the \(p < .10\) level. 
+\(p < .10\); *\(p < .05\); **\(p < .01\).

### Table 3. Structural Model Parameter Estimates for Predicting the Effects of Global and Specific Expectations on the Amount of Care Received from Children \((n = 334)\)

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Global expectations</th>
<th>Specific expectations</th>
<th>Amount of care received from children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global expectations</td>
<td>.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific expectations</td>
<td>.18*</td>
<td>.15*</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>.10</td>
<td>.28*</td>
<td>.03</td>
</tr>
<tr>
<td>Female</td>
<td>.15*</td>
<td>.05</td>
<td>.11*</td>
</tr>
<tr>
<td>Married</td>
<td>-.12*</td>
<td>-.05</td>
<td>-.04</td>
</tr>
<tr>
<td>Age</td>
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<td>.02</td>
<td>-.02</td>
</tr>
<tr>
<td>Rural</td>
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<td>.01</td>
<td>.13*</td>
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<tr>
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<td>-.19*</td>
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<tr>
<td>Number of children</td>
<td>.16*</td>
<td>.13*</td>
<td>.20*</td>
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<tr>
<td>Proximity (&lt;10 miles)</td>
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<td>.12*</td>
<td>.22*</td>
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<tr>
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<tr>
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children. Although our analysis shows support for this hypothesis, these findings raise a question concerning the circumstances that are associated with expectation adjustments. That is, which older parents are more likely to make the adjustment from high global expectations for care from children to low specific expectations?

In order to explore this question in a descriptive manner, we focused on only those respondents in our sample with "high" global expectations \((n = 171)\), that is, those with scores on the global expectation measures that were above the mean \((10.8)\). Using logistic regression, we then predicted who among this group had "low" specific expectations (i.e., below the mean of 1.5 when estimated as a continuous variable) \((n = 77)\) versus those with "high" specific expectations \((n = 94)\). We also used the sociodemographic and health characteristics of the sample as possible predictors. In addition, we included number of daughters and number of sons, because past research has demonstrated that the number of daughters influences the amount of help older parents receive (originally, number of daughters was included in the multivariate analysis presented in Table 3, but for the sake of parsimony it was dropped due to insignificant findings).

Table 4 shows the results of this additional multivariate analysis. Among the variables that characterize the older parent, only gender was a significant predictor of adjusting expectations. Among those with high global expectations, women were less likely than men to have low specific expectations (odds ratio = .2). In contrast, two of the characteristics of the children that were examined significantly predicted adjusting specific expectations. Older parents who had at least one proximate child were less likely to have low specific expectations than older parents who had no proximate children (odds ratio = .4). Finally, respondents who had greater numbers of daughters were less likely to have low specific expectations (odds ratio = .7).

These findings are consistent with the premise that circumstances in the lives of older parents affect their specific expectations for care. It appears that parents may alter their expectations (in particular, from high global to low specific) based primarily on the characteristics of their children (i.e., how many are female and how near they live) rather than on their own personal circumstances. Thus, those parents whose children live farther away may, in concept, think children should help their parents, but, in fact, they would not necessarily expect their children to help. Similarly, elderly parents appear to adjust their expectations according to the number of daughters they have. Substantial research has documented the greater involvement of daughters in parent care compared to their male siblings (Coward & Dwyer, 1990; Dwyer & Coward, 1991; Lee, Dwyer, & Coward, 1993; Litwak, 1985; Spitze & Logan, 1990; Stoller & Earl, 1983) and, apparently, elders are aware of this inclination and modify their expectations to reflect the number of daughters they have. The analysis presented in Table 4 also indicates that the gender of the elder is associated with expectation adjustments. Married men and married women may, in fact, depend differently on their spouses due to their different family roles. In other words, married older fathers may have lower expectations of help from their children because they have been less involved in raising their children (Himes, 1992), whereas older mothers, even when they are married, have "stronger" claims to intergenerational support.

**DISCUSSION**

The purpose of this study was to examine the effects of two types of filial responsibility expectations on the actual amount of care received from children among a sample of older disabled parents. Combining concepts from two theoretical frameworks (the theory of intergenerational solidarity and the theory of reasoned action), we hypothesized that global expectations would have no direct effects on receiving care from children but would affect the specific expectations held by parents, which would, in turn, directly influence the care received from children.

In sum, we found evidence supporting this modified view of the relationship between parental expectations and the amount of care received from children. The LISREL analysis indicated that specific expectations had a direct positive effect on the amount of care received from children, whereas global expectations had no significant direct effect on the amount of care received from children. However, as hypothesized in the model, global expectations had a significant indirect effect on the amount of care received from children through influencing specific expectations. These findings suggest that older parents who intend to seek care from their children actually do receive more assistance from children than do other parents. Because a measure of specific expectations implicitly takes into account issues such as the children's particular circumstances and characteristics and the alternative resources available to the elder, it offers a better estimate of the extent to which parents' expectations for assistance are actually fulfilled by their children than does a measure of global norms.

Silverstein et al. (1995) report that adult children are motivated to support their aging parents by both affection (particularly for daughters) and obligation (particularly for sons). Our analyses suggest that parents' expectations for assistance from their own children are also antecedents of children's helping behavior. This finding is consistent with the assertion that norms of intergenerational assistance are
learned in family contexts and therefore are shared to some degree by parents and children. If so, this would constitute evidence of "consensual solidarity" (Bengtson & Roberts, 1991). We do not have data on the normative orientations of the adult children associated with our sample; however, the fact that their behavior is to some degree consistent with the expectations of their parents suggests that the parents and children may adhere to similar norms.

Though the results support the idea of revising the intergenerational solidarity model to include a measure of "behavioral intentions," there are some limitations to this study that need to be taken into consideration when interpreting the findings. First, the "problems" presented in each of the expectation measures do not precisely match the dependent variable. That is, the specific expectation measure addresses expectations about four general problems (e.g., who the respondent would turn to if he or she needed help with financial problems), whereas the global measure deals with broad attitudes toward the relationship between older parents and their adult children, and the dependent variable asks specifically about help needed and provided with specific everyday tasks. The measurement of these concepts clearly influences the results. It is possible that if these concepts were measured in more comparable terms, there might be a relationship between global expectations and the actual amount of care received from children.

Second, it is certainly possible that if parents have higher expectations for care and are in greater need of care, that these circumstances would combine to affect their actual receipt of care (particularly in comparison to elderly parents who had high expectations but little need for care). Thus, parental expectations may interact with other circumstances and conditions to facilitate or impede the receipt of parent care. Research that explores the potential of such interactions may provide a fuller understanding of the effect of expectations on actual patterns of care. In fact, in analysis not shown, we tested two interaction terms that focused on the need for care. The results suggested that older parents with greater numbers of IADL and ADL limitations and who had higher expectations for care received more care from their children. A more systematic analysis of possible interactions could shed light on the process of care.

Third, there are other aspects of caregiving that we did not measure. Our focus was exclusively on older parents who were experiencing difficulties performing ADL or IADL tasks. The respondents in the Lee et al. study (1994a), in contrast, represented a random sample of community-dwelling older adults. Consequently, most of their sample was in relatively good health. Specifically, on a 4-point self-perceived health status scale (i.e., "Do you consider your current health to be poor, fair, good or excellent?"), the mean health of their sample was between good and excellent ($M = 3.1$, S.D. = 0.9). In a relatively healthy sample like that examined by Lee and his associates, the vast majority of persons would be in very little need of care and, therefore, have relatively low filial responsibility expectations for their children (as indicated previously, elders in good health generally have lower expectations of care from their children). We wanted to examine the expectations of a sample of older adults for whom the need for assistance was a more salient concern. Specifically, we wanted to examine the link between expectations and behaviors among a sample of parents suffering from physical disabilities and functional limitations due to health. We realize, however, that the results of this investigation may reflect our choice of focusing on help with ADL and IADL tasks and might not be similar for other kinds of help (such as emotional support or instrumental support).

Fourth, it is certainly possible to model caregiving in ways other than those we employed in this analysis. For instance, a proportion-based variant of the dependent variable could be constructed, which would estimate the percentage of the total number of ADL and IADL difficulties for which the respondent received help from children. In that context, researchers might explore the antecedents and consequences for parents who rely differentially on their children for help. Future research might compare and contrast varying strategies for conceptualizing and measuring parent care.

Furthermore, these relationships between expectations and the amount of care received may be better addressed in a more disabled or a more "cared for" sample. It is certainly possible that there would be differences in the effects of expectations on care received between severely and moderately disabled samples of elders. Though elders with more disability are likely to experience more instances of care from children, there may in fact be a threshold when this relationship changes. In other words, it is possible that elders are able to receive care from their children until they develop severe disabilities, when either institutionalization or professional home health care becomes a necessity. It would be an important step in research on these issues to examine these relationships in different samples, such as a more disabled sample.

Finally, an important limitation of the dependent variable that we employed is that it is a mixture of both intensity and duration of care. We realize that it is certainly possible that in this study two elders with the same score on the amount of care received from children (e.g., a score of 10) could actually be quite different. In other words, for one person the score may reflect receiving help with 10 tasks in one wave, while for another person the same score could reflect receiving help with three tasks in one wave, three tasks in another wave, and four tasks in the final wave. The first elder may have had an acute illness that required a concentrated period of assistance, whereas the other elder may have more chronic health conditions. These two elders would receive quite different patterns of care, but in our study they would have been assigned the same score. Future researchers may find it useful to disaggregate measures of care over time to determine if there are varying predictors of intensity and duration.

These findings have important implications for future research on intergenerational support relationships. For example, the connection between the matching of expectations and the receipt of care may have an important influence on the mental health of older adults. Though earlier research found that parents' filial responsibility expectations are negatively related to morale (Kerckhoff, 1966; Seelbach & Sauer, 1977), this finding could be a statistical
artifact of not accounting for the matching of specific expectations to the actuality of receiving care. It is entirely possible that the parents who had high expectations for care did not receive the care they expected, and therefore had low morale. Another possibility is that low expectations for care and high levels of care have negative effects on mental health (Krause, 1987, 1995; Silverstein, Chen, & Heller, 1996). It is important for researchers to address the matching of expectations to reality because of the important implications for mental health in the older population.

Another direction for future research involves taking into account the past history of helping between parent and child. For example, if a respondent had previously received help from his or her children while recovering from a mild heart attack, then this past “behavior” would certainly influence current “expectations” for care. In the study reported herein, this prior experience was not taken into account, and therefore the influence of past experiences was not measured. Future researchers may want to construct some indication of these past experiences in order to determine the degree to which they account for variations in current expectations among older adults.

Finally, the findings from our study suggest that we need to understand better the dimensions and attributes of the childrens’ situations that elders take into account when they adjust or modify their global expectations. It will be through this line of inquiry that we will be better able to understand caregiving patterns and the effectiveness of different types of caregiving networks.

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