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ARTICLE

Values and the experience of family care-giving: cultural values or shared family values?

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Abstract

The Sociocultural Stress and Coping Model focuses on the role of cultural values in shaping the stress and coping process for family care-givers of frail older adults. The literature suggested ethnic group-specific values as influences. The current study explored care-givers' perceptions of values influencing caring to identify values not addressed in quantitative studies of cross-cultural care-giving. Seventeen family care-givers from Australian Aboriginal, Romanian-Australian, Pacific Island and white non-immigrant Australian backgrounds participated in semi-structured interviews about their care-giving experience and the role that values played in caring for a frail older adult. Thematic analysis of the interview transcripts led to identification of themes of cultural values of familism and care for frail older adults, religious values of filial piety and religious coping, love, reciprocity and responsibility/obligation. While cultural values influenced family care *versus* institutional care, religion was a more clearly identified source of values. Care-givers mostly shared values of love, reciprocity and responsibility/obligation rather than endorsing culture-specific values, with potential variations in expression between individualist and collectivist cultures. These findings suggest that the focus on cross-cultural differences may have missed core values shared across cultural groups and underestimated the influence of religion on care-giving values. Future research could focus on these perceptions of care-givers themselves rather than external perceptions of researchers and service providers.

Keywords: family care-giving; culture; values

Introduction

Understanding the influence of cultural values on the physical and mental health of family care-givers for frail older adults is increasingly important as the global population becomes more ethnically diverse (Fearon, 2003). With regard to the care-giving literature, cultural values are defined as the attitudes and beliefs about family and frail older relatives that can influence the understanding of the care-giving experience. In general, care-givers of Western European cultural background are seen as strongly individualistic with others (non-Western countries and minorities and immigrants within Western countries) influenced by familism values. Cultural values are thought to have both positive and negative consequences for the care-givers (Roth *et al.*, 2015).

Caring for an older adult has long been known to be associated with negative physical and psychological health outcomes (Schulz *et al.*, 1995; Pinquart and Sörensen, 2003; Losada *et al.*, 2010). High levels of care-giver strain have been found to lead to a higher mortality and morbidity risk for the care-givers (Schulz and Beach, 1999; Vitaliano *et al.*, 2003). These negative consequences have implications for care-givers, and for health and social services. With population ageing, it is important to understand the consequences of family care-giving for frail older adults.

Both quantitative and qualitative studies have increasingly focused on positive consequences as well (Carbonneau *et al.*, 2010). Care-givers who identify positive experiences of care-giving report fewer negative health effects (Carbonneau *et al.*, 2010; Lloyd *et al.*, 2016). Enhancing positive experiences that care-givers have may buffer negative effects (Carbonneau *et al.*, 2010; Tang and Chan, 2015). Carbonneau *et al.* (2010) proposed three domains of positive aspects of care-giving: (a) the quality of the relationship between care-giver and recipient, (b) finding meaning, and (c) feeling accomplished. Care-givers' values, including cultural values, are likely to play a role in finding meaning and feeling accomplished.

Theoretical framework: the Sociocultural Stress and Coping Model

The Sociocultural Stress and Coping Model (SSCM; Aranda and Knight, 1997; Knight and Sayegh, 2010) was adapted from the coping model of Lazarus and Folkman (1984) to explore the role of cultural values in the stress and coping process of care-givers for older adults. As in the Lazarus and Folkman model regarding the role of perceived stress in general stress and coping, the emphasis of the SSCM is on the perception of care-giving as burdensome as a main influence on health outcomes. The research underpinning the model was primarily quantitative and the focus on cultural values was on the contrast between individualism values *versus* collectivist familism values. Individualism values are prominent in Western cultural groups with historical roots in Europe, which are also the source of much of the care-giving stress and coping research. These values place the emphasis on the individual's rights and needs, and so caring for a frail older family member is likely to be seen as a disruption of the individual's life. With regard to cultural differences in the view of the self, Landrine (1992) characterised the Western self as a free agent emphasising independence and control to meet one's individual needs. Familism is the family-focused aspect of collectivism where the emphasis is on the group and what the group (in this instance the family) needs. In Landrine's view, the collectivist self exists in those relationships and interactions. For care-givers, the expectation would be that familism values would lead to seeing care-giving as a natural part of family life and thus to lower burden perceptions and better health outcomes.

However, Knight and Sayegh (2010) found in their review that familism questionnaires largely measured obligation and led to avoidant coping and worse health outcomes. They urged that future research focus on looking for distinct cultural values across ethnic groups (*e.g.* filial piety) and that future research ask care-givers about the values that influenced care-giving.

In this project, we planned to explore the values of care-givers of frail older adults who were from three potentially quite different cultural backgrounds: (a) white non-immigrant care-givers who, given the strong historical and cultural linkage to the United Kingdom (UK) with later influences from the United States of America (USA), were expected to share care-giving values common to other Western cultural groups; (b) indigenous Australian care-givers; and (c) Romanian-Australian care-givers. While the selection of ethnic groups was in part due to accessibility to the research team, the groups provide potential contrasts between Western culture, an indigenous cultural group and an immigrant group that is high on familism values but not a visible minority nor part of Eastern culture.

Non-immigrant white Australians

Non-immigrant white Australians are taken as an example of Western culture.[1] However, the Knight and Sayegh (2010) review of that literature would also imply that being low on familism as measured in most quantitative research would mean that Western care-givers would have a lower felt obligation to care for frail older relatives and so the ones who do volunteer for care-giving may experience better health outcomes. This difference between the concept of familism as a cultural value and the measurement of it in quantitative studies may explain the unexpectedly low to null impact of familism values on perception of burden and the negative impact on coping styles and social support noted by Knight and Sayegh (2010).

The qualitative literature on care-giving has largely focused on Western care-givers to date. That literature has revealed that care-givers themselves frame their values in terms of love for the family member, reciprocity (especially when relationship quality was good) and responsibility (Lloyd *et al.*, 2016; Joling *et al.*, 2017). Joling *et al.* (2017) noted that care-givers but not professionals responding to their Delphi poll cited the quality of the relationship as an important influence on their experience of caring. To the best of our knowledge, it is not known at this time whether these values would be shared by other cultural groups or would differ in some ways.

Aboriginal Australian care-givers

Indigenous Australian care-givers are an exemplar of a cultural group with strong familism values and other non-Western European values. They have a long continuous history in the Australian continent. The Aboriginal population has multiple characteristics of disadvantaged minority group status, including higher levels of economic disadvantage, disease and unemployment (Commonwealth of Australia, 2020).

Chronic health conditions affect 88 per cent of Aboriginal or Torres Strait Islander people over the age of 55, with higher risks of diabetes, cardiovascular disease and respiratory disease, among others (Australian Institute of Health and Welfare, 2017). In the 2016 Census, 27 per cent of older Aboriginal and Torres Strait Islander people reported a need for assistance, compared with 19 per cent of non-Indigenous people aged 65 and over (Australian Bureau of Statistics, 2016). The prevalence of dementia in remote Aboriginal communities has been estimated at around 12–13 per cent, approximately five times greater than reported for the corresponding age group in the wider Australian population at 2.4 per cent (Smith *et al.*, 2008; Radford *et al.*, 2014). Therefore, it is important to understand the process of caring within an Indigenous family context.

There is limited research on caring for Australian Aboriginal frail older adults, including those with dementia. Much of the literature that does exist focuses on remote communities of Aboriginal people that struggle with poverty, very limited service ability and within which frail older adults may have considerable difficulty getting needed support (Lindeman *et al.*, 2012). The majority of Aboriginal Australians live in urban areas; environments where they have more access to services but those services are provided by mainstream providers and may entail some degree of adopting white Australian interpretations of frailty and care (Arkles *et al.*, 2018).

Romanian-Australian care-givers

The global increase in international migration affects the experience of care-giving, contributing to increased diversity (Torres, 2019). The cultural values of some immigrants are a mix of nation of origin and host country values, a mixture that does not resemble the old or new culture (Torres, 2019).

In a qualitative study conducted in the UK, Willis (2012) proposed that ethnic identity becomes salient after immigration and joining an ethnic minority group in the new country. Further, a strong sense of ethnic identity is linked with identifying with the collective rather than the individual, which she suggested is why the non-immigrant participants in her study gave an individualist account of motivations for informal care, whereas the immigrant participants gave a collectivist account.

Romania is situated in south-east central Europe, with a culture based on Latin origins and Christianity (Nadolu *et al.*, 2007). It is one of the most religious countries in the European Union. Approximately 81 per cent of the population identified as part of the Eastern Orthodox Church in 2011, 4 per cent are Catholics and approximately 6 per cent are Protestants (National Institute of Statistics, 2011).

Romania has a strong tradition of familism values, filial norms based on respect and affection for older parents in Romania (Ingelhart and Baker, 2000; Daatland *et al.*, 2011; Zimmer *et al.*, 2014). Parents are the most important source of support for their children, and when they cannot care for themselves, they live with the younger family members who provide care, and moral and emotional support (Nadolu *et al.*, 2007; Rada, 2014; Zimmer *et al.*, 2014). These parent–child relationships are a natural part of the lifecycle, representing a balanced exchange that benefits both parents and children (Rada, 2014).

Thus, Romanian-Australian care-givers provide an example of an immigrant group's experience of care-giving. They also provide a novel example of a familism-oriented and religious culture of European origins which can contribute to existing literature on cultural differences by separating familism values from visible minority group status and from the Western *versus* Asian cultural contrast.

The present study

We explored care-giver values in this culturally varied set of care-givers using thematic analysis of individual interviews conducted by members of our research team. Qualitative research can explore people's complex behaviours, practices and experiences to gain a deep understanding of the subtle nuances of people's thoughts and feelings in a way that is difficult to achieve through other methods (Braun and Clarke, 2006). This method is particularly useful when exploring the personal experiences of people whose views have not been recorded before, as it allows for more open responding.

In this study, we were looking for cultural values beyond the individualism/familism dimension that has been used in quantitative research on cultural values and care-giving, and we explored whether these values may differ among: (a) white non-immigrant Australians who are expected to be similar in values to the Western care-givers who are the subject of much of the English-language research on care-giving, (b) those from Aboriginal and Torres Strait Islander backgrounds, and (c) Romanian-Australians. While we had specifically recruited participants from these three groups, we were open to participants from any cultural background and two participants had Pacific Islander heritage.

Method

Researchers

The research team consisted of three student researchers and one faculty researcher. The student researchers were the interviewers for the study. Three of the four research team members were immigrants to Australia: one from Romania, one from Ireland and one from the USA. Two of the team members had personal experience as family care-givers and the faculty researcher has been active in care-giving research and services for a number of years.

Participants

In order to be included in the study, the participants needed to be providing care for an older person. A older person was defined as someone over the age of 55 who has care needs such as cognitive decline, dementia and physical frailty. Seventeen care-givers were recruited in total. Five of the participants identified as Aboriginal Australian, four were Romanian-Australian, six were white non-immigrants and two had Pacific Islander heritage from different islands with distinct cultures. We have included the Pacific Islander participants in the analysis, but we had no research questions about them given the lack of research literature about care-giving values for this group.

The research was conducted with the approval of the Human Ethics Committee of the University of Southern Queensland.

Seven participants were recruited through the personal connections of the co-authors. These included the four Romanian-Australian care-givers and three of the white non-immigrant care-givers. The majority of the care-givers lived in the state of Queensland, Australia, two were from other states in Australia. Advertisements were shared with personal networks of the researchers through social media. Flyers were also put on community noticeboards and at researchers' workplaces. Romanian-Australian care-givers were recruited using similar methods and also by contacts through multicultural formal service providers. The invitations to participate were informal.

The other ten participants were recruited via a care-giver support organisation, Carers Queensland. Care-givers were informed about the research during three events hosted by Carers Queensland, and were invited to approach the researcher if they wanted to participate. For a summary of the participants with their pseudonyms, *see* Table 1.

Interview processes

Data were collected through semi-structured interviews; all were conducted in English. Interviews were scheduled at a time suitable for the participants. The majority of the interviews took place in the care-givers' homes, two were in cafes at the participant's request and two were by telephone. The semi-structured approach enabled the participants to discuss issues of prime concern, to encourage participants' sharing of underlying beliefs, attitudes and cultural impact on their care-giving experience. The interview questions were kept deliberately open-ended and neutral to facilitate the exchange and to minimise influencing participants' responses. The participants were asked about their care-giving experience, who they care for and what motivated them to provide care. They were also asked if they could identify positive aspects in their role, and about their personal values. Cues were provided for participants to talk with a minimum amount of interruption or constraint by the interviewer. Each interview lasted approximately an hour, and was audio recorded with permission from the participant. This allowed for uninterrupted attention and interaction within the interview, as well as providing a complete record for transcribing and data analysis.

Analysis

Thematic analysis was employed in order to explore the reported understandings of caring for a frail older family member by the participant care-givers, in particular to find out what role, if any, they felt that their culture played in their understanding of care-giving. The epistemology for our analysis was experiential in that we took the participants' accounts of their care-giving experience as describing the reality of their experiences in the context of caring for a frail older adult and in the context of their cultural and other values as they expressed those values (Braun and Clarke, 2021). Thematic analysis is a qualitative method used for identifying, analysing and reporting patterns or themes within data. Each theme captures something important about the data in relation to the research question. An inductive thematic analysis is a process of coding the data for themes without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions (Braun and Clarke, 2006).

The process has been described and outlined in a step-by-step approach by Braun and Clarke (2006). The first stage in the analysis consisted of transcribing the audio interview files, saving them securely and then de-identifying the

Table 1. Descriptive information about participants

Pseudonym	Ethnicity	Gender	Age	Relationship	Care recipient's age	Care recipient's diagnosis
George	Aboriginal	Male	60	Spousal	56	Kidney disease and arthritis
Tina	Pacific Islander	Female	61	Spousal	59	Acquired brain injury, dementia and diabetes
Claire	White	Female	71	Spousal	73	Dementia and diabetes
Louise	Pacific Islander	Female	58	Parental	82	Dementia
Emma	Aboriginal	Female	77	Friend	85	Dementia
John	White	Male	69	Parental	94	Dementia
Sharon	White	Female	79	Spousal	82	Dementia and arthritis
Daniel	Aboriginal	Male	73	Spousal	69	Stroke, dementia and emphysema
Grace	Aboriginal	Female	43	Parental	63	Diabetes and hearing impairment
Ann	Aboriginal	Female	40	Parental	81	Diabetes and asthma
Phoebe	White	Female	63	Spousal	77	Heart condition with disability
Monica	White	Female	62	Parental	92	Alzheimer's disease
Rachel	White	Female	61	Spousal	62	Frontal-temporal dementia and physical disability
Anna	Romanian-Australian	Female	65	Parental	91	Dementia and cancer
Hadessa	Romanian-Australian	Female	51	Parental	77	Dementia
Helen	Romanian-Australian	Female	52	Parental	77	Heart disease and mild dementia
Lily	Romanian-Australian	Female	55	Parental	90	Dementia and unable to walk

transcripts using pseudonyms for each participant. The transcripts were read through three times by researchers, with initial ideas noted down on the second and third readings. In the second stage of analysis, the transcripts were read through again and coded using the qualitative software program NVivo 12 (QSR International, Melbourne). The data were coded in a systematic fashion as the transcripts were read, with data related to each code saved to that code – noting that some data could be allocated to a number of codes in this stage. Following this, in the third stage the codes were gathered into potential themes, with similar codes grouped together into each theme. To further explore the meaning of the narrative in each code, the researchers discussed in pairs the codes and themes in this third stage of analysis, to ensure that the meaning was consistent and coherent between both individuals. In the fourth stage, the codes within each theme were checked to ensure they reflected each theme properly and that they were accurate representations of each theme in relation to the rest of the data; that is that they did not better represent another code or theme. In the fifth stage, the themes were further refined and named; data were removed from any theme that was not a good fit for that named theme. Themes were renamed as needed to best reflect the data in that theme. Finally, this report was written selecting extracts from the transcripts that best reflected each theme, with respect to the original research questions and also to represent each participant's views accurately.

Findings

Five themes were identified from the interviews: culture-specific values of familism and care for frail older adults, religious values of filial piety and religious coping, love, reciprocity and responsibility/obligation. Based on previous quantitative research (*e.g.* Knight and Sayegh, 2010), we brought to the data particular interest in the role of culturally specific values. While we did not force that theme on to the interview data, the focus on cultural values originated more from previous work with the sociocultural stress and coping theory whereas the other themes were outcomes of the inductive process described here.

The quotes illustrating themes are identified with the pseudonym given to the care-giver, gender, ethnicity and relationship to the care recipient (spouse, child). For the themes and key quotations, *see* Table 2.

Culture-specific values: familism and shared care for the frail older adults

We had a particular interest in the role of culture in shaping care-givers' values and responses to caring for a frail older adult. In general, cultural answers focused on the expectation that care would be provided by family and that caring for older adults was a natural part of life.

The findings of the current thematic analysis identified viewing caring for an older family member, or any family member, as a natural part of family life as a key theme. This perspective was advanced by participants from immigrant backgrounds as well as Aboriginal interviewees. An explicit reflection on cultural values of familism and the contrast with Australian values comes from a Romanian immigrant care-giver:

Table 2. Identified values themes

Themes	Key quotations
Culture-specific values:	
Familism	It probably does come a lot from my culture, 'cause I think the Romanian culture is very family orientated. I think probably in many ways probably more than the Australian culture
Shared care for frail older adults	I ask other elderly people if they need help or something like that. I notice my siblings did that yesterday as well
Religious values:	
Filial piety	Like it's clearly in the Bible it says honour your mother and father
Religious coping	I believe in God being with me all the time so that helps me too because I get strength from him
Love	Well it's a heart decision, not a money decision, not a business decision, it's a heart decision obviously you love your mum you want what's best for her
Reciprocity	It's not like I don't get anything back from [husband], I get heaps of love back from him
Responsibility/obligation	You feel responsible for her being, and responsible for her health and her mind and for kind of wellbeing

> It probably does come a lot from my culture, because I think the Romanian culture is very family oriented. I think in many ways probably more than the Australian culture. Australians seem … well my friends that have looked after their parents consider they look after their parents by putting them in nursing homes and visiting them every day. (Anna, woman, Romanian, child)

Tina noted that these familism values extend beyond the frail older relatives and to the family more generally. She remarked on this being extended family, quite likely a further contrast with the nuclear family focus of Westerners including white, non-immigrant Australians:

> I think so because of where I'm coming from and how we are brought up. You look after one another and you support any family, extended family members, anyone who gets sick. We all chip in. (Tina, woman, Pacific Islander, spouse)

An Aboriginal care-giver framed the cultural values around caring for older adults more broadly as well to include older adults in general, not only family members. This framing suggested a value of care for elders regardless of whether they are related:

> I ask other elderly people if they need help or something like that. I notice my siblings did that yesterday as well, so maybe that's something that Mom taught us from [when we were] young and it's probably part of our culture as well to respect our elders. (Ann, woman, Aboriginal, child)

While Ann used the phrase 'respect for elders', we see this as an example of shared caring for all elders, not simply showing respect for their age.

Some of them also noted, however, that alternative care arrangements had not been available to their families. While cultural values of familism and shared care for the elders were evident, this qualification raises the question of whether these values motivate family care or rationalise the absence of societal alternatives to family-based care. The absence of those societal resources could themselves be taken as an indication of community-level to national-level expressions of shared values. Denham (2016) noted that institutional care of frail older adults in Great Britain goes back to at least 1601 with the establishment of almshouses. Religious orders provided care even earlier.

> My … culture, from what I believe, my ancestors, my grandparents they were all looked after by their daughters. Back in those days there was no aged care facility, so everybody had to look after them, but that's a huge thing in [our] culture. (Louise, woman, Pacific Islander, child)

> Yes at home, and probably over there we didn't have the facilities we have here in Australia. But it's not necessarily a good thing … sometimes they [these old people] could be disadvantaged by staying at home for too long. (Lily, woman, Romanian, child)

It should be noted that all responses clearly related to the influence of familism values or care for older adults in general on care-giving were from respondents other than the white non-immigrant Australians. This absence of comment on these values may reflect their relative absence in Western society. It may also reflect the long-term history of having institutional care alternatives available in Western nations, which itself exemplifies a long-standing cultural stance towards care of frail older adults.

Religion as a source of care-giving values: filial piety and religious coping

Religious values emerged as a theme from the interviews. Religious values and cultural values can be similar in content and their influence, but differ in that cultural values would follow the sense of being part of a national or ethnic identity whereas religious values would follow identification with that religion which could be both larger (*e.g.* the transnational distribution of Christianity and of Confucian values) or smaller (religious differences within a national or ethnic identity).

All of the Romanian-Australians described religion as an influence in their care-giving. The role of religion in the care-giving values of the Romanian-Australian care-givers is not surprising given the very strong role of religion in Romanian culture (Nogolu *et al.*, 2007):

> My beliefs, my religion, like it's clearly in the Bible: it says honour your mother and father, and … I believe it. And it's satisfying, not satisfying, it's fulfilling when you actually do this as a child. (Hadessa, woman, Romanian, child)

Hadessa's beliefs, based in Christian scripture, are similar to the cultural value of filial piety seen in Confucian values, involving both honour or respect for parents but also emphasising the role of caring for and loving parents. Her statement that living up to this value is fulfilling is an important aspect of the role of this Christian religious value in her care for her mother.

> I think [it's] probably just my attitude to life. I teach laughter yoga and meditation, chair yoga now, but we do dancing and laughter, and I advocate that they have a book [to note] the funny things in life. They write five things down a day and we all have a good laugh about it. (Emma, woman, Aboriginal, friend)

Emma's values emphasise the management of feelings and enjoying time out from care-giving. It is also of interest that she embraced a religious tradition outside her own cultural background, an example of the potential distinction between cultural and religious values connections.

> And also I'm Christian I believe in God being with me all the time so that helps me too because I get strength from him. (Sharon, woman, white Australian non-immigrant, spouse)

Sharon's religious focus is on her sense of getting strength from her connection with God. In the care-giving stress and coping literature, both Emma and Sharon are using religious coping.

While the importance of religion in shaping care-givers' values for the Romanian heritage care-givers is especially clear, these findings suggest that more attention be paid to the role of religion and spirituality in shaping the experience of care-givers more generally. Since religion often involves participation in religious activities and typically has an explicit teaching component involving values, the influence of religion is likely to be more apparent and explicit in care-givers' reflections than the influence of culture.

Love

The most common value providing meaning for being a care-giver for the frail older adult was love. This is consistent with other qualitative literature focused on Western care-givers. These findings extend that observation to other cultural groups. While love for spouse and love for parents is clearly different, the care-givers in this study did not make explicit distinctions in their responses:

> I think basically it's the love I have for him. Just because you love that person unconditionally, irrespective of anything. I think that if I didn't love that person, I probably would have packed my bags and left a long time ago. (Tina, woman, Pacific Islander, spouse)

> Well it's a heart decision, not a money decision, not a business decision, it's a heart decision. Obviously you love your mum [and] you want what's best for her … I love my mummy. (Hadessa, woman, Romanian, child)

> It's a must. Because I love her so much, this is the only way I can repay her. (Daniel, man, Aboriginal, spouse)

While these were uncomplicated positive expressions of love that made caring easier, for other care-givers there was clearly a more mixed picture. For these care-givers, the changes in the care recipient as they became frail altered that sense of emotional positivity into persisting commitment or to a sense of estrangement from the person being cared for. Of interest, only white non-immigrant care-givers offered these more ambivalent examples. Perhaps this is an indication of a more marked sense of individuality in Western care-givers and whether the relationship is continuing to meet the care-giver's needs:

> Loving him and the fact that I promised for better or for worse, richer, poorer, sickness and health till death us do part. I promised it so that's it. I've got to hold on to my promise. (Sharon, woman, white Australian non-immigrant, spouse)

> He's not the person I married, fell in love with, or anything else like that. I still love him, but he's just: like, I don't know who he is. (Rachel, woman, white Australian non-immigrant, spouse)

Reciprocity

As in other qualitative research on care-giving, reciprocity as well as love was a common theme in our interviews. In some instances, the reciprocity was seen as unfolding over the course of the relationship and expressed in the sense that the care recipient would do the same if the care-giving situation were reversed:

> Yeah, humble and respect and both ways: she [would] do the same for me, and I do the same for her. (George, man, Aboriginal, spouse)

In other care-giving relationships, the reciprocity was expressed in immediate terms. The care recipient was perceived as a source of ongoing emotional support:

> It's not like I don't get anything back from [husband], I get heaps of love back from him, we laugh every day. We're still the same, except every day's a weekend now, so it hasn't changed there. I get so much back from doing this. (Phoebe, woman, white Australian non-immigrant, spouse)

Child care-givers expressed the reciprocity in terms of specific exchanges: caring now for a parent who had provided care for the care-giver's child in an earlier phase of life:

> So in her previous years my mother was a great help to me. She was able at times, many times, to take care of my son so I could go to work. Now that's changed, I needed to stop working to take care of her, so this is what I've done. And it is a reciprocity, because she helped me and I decided to help her as well. (Lily, woman, Romanian, child)

> Well my dad has cared for me. And I'm single parent, and he lived in Brisbane and I lived in Melbourne, and … he often fixed things like my roof or guttering or anything major that I couldn't do. He would step in and do some of those things. And I often thought of how he cared for me when I had certain issues with my former husband, I won't go into them, but he was always there for me. (Anna, woman, Romanian, child)

> You know, um, 'You wiped my bottom enough for me when I was little so I guess I can repay the favour'. (Monica, woman, white non-immigrant Australian, child)

In our interviews, most of the examples of reciprocity came from children caring for their parents. Those examples mainly were phrased in terms of paying back for care received earlier in the child's life, but often for help received in adulthood rather than for the parent's care for them as a child. When spouses discussed reciprocity, it was present-time reciprocity in the give and take of the marriage. These examples call attention to the importance of perceived reciprocity. While more research is needed, in these interviews reciprocity was presented in positive terms as value supporting family care-giving.

Responsibility and obligation

These interviewees spoke of both responsibility and obligation with most using the term responsibility. In our findings and in the qualitative literature broadly, responsibility has a positive connotation and a sense of living up to personal values, potentially linked to the finding meaning path to positive aspects of care-giving found in other studies:

> She really really needs you and it's a big responsibility. It is a big responsibility and yeah in a way you feel responsible for her being, and responsible for her health and her mind and for kind of wellbeing and everything that comes with it. (Lily, woman, Romanian, child)

> I have a feeling of um … knowing that I've done the right thing. Or what I consider to be the right thing … I've always had a very strong sense of um, I don't know, responsibility I guess or, you know, wanting to help, wanting to be the helper. (Monica, woman, white Australian non-immigrant, child)

A distinct difference in findings from qualitative and quantitative research on care-giving values is that qualitative studies asking the care-givers to describe values in their own words tend to find this positive focus on responsibility giving meaning to care-giving.

Quantitative studies with existing measures have focused more on obligation and associated negative effects.

Discussion

This research began with questions about the values that would shape care-givers' constructions of caring for older frail family members with a particular interest in exploring for cultural values beyond the individualism/familism dimension. Previous research using quantitative methodologies and focusing on the familism/individualism dimension (Knight and Sayegh, 2010) found that familism as measured in the scales used had a strong component of obligation and was associated with negative outcomes. That line of research also suggested that cultural values might be more group-specific than had been expected and led to recommending qualitative research to help identify those values.

These findings indicated that cultural values of familism and care for frail older adults are more salient to care-givers when they have exposure to values different from their own. Immigrant and Aboriginal participants alluded to cultural influences, non-immigrants did not. As noted by others studying culture, it can be so pervasive as to be invisible (*e.g.* Qureshi, 2005). Care-givers who referred to culture generally saw the cultural values influence as leading to seeing caring for frail older relatives and in some instances older adults outside the family as a natural part of family life. That view is consistent with expectations about familism values but distinct from measures of familism used in quantitative research that have strong components of obligation to care. Care-givers also referred to shared care for frail older adults in general as a cultural value.

Some care-givers citing that value perspective also noted that other aged care options were not available and so the choice was family care or no care. The presence or absence of institutional aged care can also be taken as an expression of cultural values at the societal level rather than the individual or family level. Denham (2016) pointed to the long history of institutional aged care in Western society.

A more salient source of values shaping care-giving according to our interviewees was religion. This finding serves as a reminder that the influence of religion and religious values has often been overlooked within the care-giving literature. These findings are consistent with those of the qualitative research of Levkoff *et al.* (1999) with a range of American minority care-givers in confirming the importance of religion as a source of values for care-giving. Lloyd *et al.* (2016) have also noted the importance of faith and spiritual growth in positive reactions to caring in mostly white Western samples. Religious values were cited here as supporting filial piety, a positive approach to life in general, and religious coping by having an ongoing sense of God's help.

On the whole, the values that shaped understandings of care-giving were common across cultures and were personal: love, reciprocity and responsibility. Care-givers themselves construct the meaning of their care-giving within these terms and do so across the cultures included in this study. Lloyd *et al.* (2016) mention the importance of commitment to the relationship and also the role of relationship gains in supporting positive caring experiences. Joling *et al.* (2017) noted that relationship quality was cited by care-givers but not by professionals as an essential aspect of resilience in the caring role. Lloyd *et al.* (2016) reported that the care-givers noted reciprocity as an important contributor to a positive experience of care-giving, when the previous relationship had been positive.

However, there were exceptions among the non-immigrant Australian care-givers in the enduring positive impact of love. Western individualism would seem to lead to a more ambivalent or critical stance towards the relationship, even when the care-giving continues. It may well be that the individualism values lead to a greater focus on the equity of the social exchanges involved in reciprocity over time.

Social psychological theories of reciprocity include focus on social exchange and equity in relationships with the perception of roughly equal exchange being important in maintaining a positive relationship (Carruth, 1996; Reid *et al.*, 2005). For families, and especially for children caring for parents, the perception of equity in those exchanges may be based on extended periods of time, and that appears in some of our interviews. This reciprocity cited by child care-givers was often for help received from parents as an adult rather than for being parented as in childhood. To our knowledge, this finding of the importance of parental care in adulthood to later care-giving of the frail parent by the child is novel. Present-time equity in the care-giving relationship may be particularly challenging with the progression of dementia as the care recipient becomes more cognitively impaired and unable to share tasks or to express love, appreciation and eventually even recognition of the care-giver.

Knight and Sayegh (2010) noted the negative impact of obligation values as tapped by scales intended to measure familism in quantitative research. Another measure of cultural values, the Cultural Justification for Caregiving Scale, has been found to have two factors of Duty and Reciprocity (Powers and Whitlatch, 2016). del Pino Casado *et al.* (2011) also used those contrasting values, measured differently, in research on care-giving. Duty in those studies was not generally found to be associated with negative or positive outcomes. Lloyd *et al.* (2016) noted that qualitative studies of the sense of duty suggested that fulfilment of duty leads to rewards, although more often for spouses than for children. Future research on care-giving values, quantitative and qualitative, is needed to further clarify the distinction between obligation and responsibility or sense of duty and whether they are related to differing outcomes for care-givers' distress and health.

From the emic perspective of care-givers themselves, these personal feelings and values are the principal motivations of caring for frail older family members. Among our interviewees, these values were common across cultural identities. The etic perspective common to quantitative research has tended to look for values differences at broad ethnic group levels and to date has focused on the familism/individualism construct as an East/West difference and a majority/minority group difference (Knight and Sayegh, 2010).

Limitations

One important limitation of this research is that while Romanian-Australians were interviewed by a Romanian-Australian team member and we were able to interview several Aboriginal care-givers, all of these Aboriginal participants were living in a large town (a potential indicator of acculturation compared to those living in small largely Aboriginal communities), were recruited through Carers Queensland and the interviewer was not herself Aboriginal. Aboriginal care-givers were also recruited through organisational contacts rather than personal connections of researchers as was true for Romanian-Australians and for some of the white non-immigrant care-givers, and this difference in recruitment may have affected results. The view of Aboriginal culture this provided may well be influenced by these circumstances and involvement of an Aboriginal researcher would be desirable in future research. Nonetheless their inclusion adds to a limited research literature on Aboriginal culture and care-giving. Also note that the majority of Aboriginal people in Australia live in towns and cities rather than in Aboriginal communities and so this study adds to the limited research on Australian Aboriginal care-givers with a focus on those living in such locations.

Conclusion

This study adds to the qualitative literature on values in care-giving by including care-givers from three distinct cultural backgrounds. Care-givers describing the values motivating their care-giving spoke in terms of love, reciprocity and responsibility across these cultural backgrounds. Culture was referenced by care-givers who were immigrants or from minority backgrounds and thus contrasted their values with perceived Australian mainstream values. Religion was more clearly cited as a source of care-giving-related values, especially by Romanian-Australians whose traditional culture emphasises religion more than is typical of cultures with Western European heritage.

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Ethical standards. The research was conducted with the approval of the Human Ethics Committee of the University of Southern Queensland (H18REA256).

Note

1 There is, of course, a sense in which all white Australians are immigrants. We use the phrase to indicate that they are not recent immigrants with values rooted in Europe, North America, *etc*.

References

Aranda MP and Knight BG (1997) The influence of ethnicity and culture on the caregiver stress and coping process: a sociocultural review and analysis. *The Gerontologist* **37**, 342–354. doi: 10.1093/geront/37.3.342.

Arkles R, Jankelson C, Radford K and Jackson Pulver L (2018) Family caregiving for older Aboriginal people in urban Australia: disclosing worlds of meaning in the dementia experience. *Dementia* **19**, 397–415.

Australian Bureau of Statistics (2016) *Census of Population and Housing: Reflecting Australia – Stories from the Census* (Cat. No. 2071.0). Canberra: Australian Bureau of Statistics. Available at https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Snapshot%20of%20Australia,%202016~2.

Australian Institute of Health and Welfare (2017) *Australia's Welfare 2017*. Canberra: AICLAIR.

Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77–101.

Braun V and Clarke V (2021) Conceptual and design thinking for thematic analysis. *Qualitative Psychology* **9**, 3–26.

Carbonneau H, Caron C and Desrosiers J (2010) Development of a conceptual framework of positive aspects of caregiving in dementia. *Dementia* **9**, 327–353.

Carruth AK (1996) Development and testing of the Caregiver Reciprocity Scale. *Nursing Research* **45**, 92–97.

Commonwealth of Australia (2020) *Closing the Gap Report*. Available at https://ctgreport.niaa.gov.au/content/closing-gap-2020.

Daatland S, Herlofson K and Lima I (2011) Balancing generations: on the strength and character of family norms in the West and East of Europe. *Ageing and Society* **31**, 1159–1179. doi: 10.1017/SO144686X10001315.

del Pino Casado R, Frías OA and Palomino MPA (2011) Subjective burden and cultural motives for caregiving in informal caregivers of older people. *Journal of Nursing Scholarship* **43**, 282–291.

Denham M (2016) *A Brief History of the Care of the Elderly*. Available at https://www.bgs.org.uk/resources/a-brief-history-of-the-care-of-the-elderly.

Fearon JD (2003) Ethnic and cultural diversity by country. *Journal of Economic Growth* **8**, 195–222.

Ingelhart R and Baker WE (2000) Modernization, cultural change and the persistence of traditional values. *American Sociological Review* **65**, 19–51. doi: 10.2307/2657288.

Joling KJ, Windle G, Dröes R-T, Huisman M, Hertogh CMP and Woods RT (2017) What are the essential features of resilience for informal caregivers of people living with dementia? A Delphi consensus examination. *Aging and Mental Health* **21**, 509–517.

Knight BG and Sayegh P (2010) Cultural values and caregiving: the updated sociocultural stress and coping model. *Journals of Gerontology: Series B* **65**, 5–13.

Landrine H (1992) Clinical implications of cultural differences: the referential versus the indexical self. *Clinical Psychology Review* **12**, 401–415. https://doi.org/10.1016/0272-7358(92)90124-Q.

Lazarus R and Folkman S (1984) *Stress, Appraisal, and Coping*. New York: Springer.

Levkoff S, Levy B and Weitzman P (1999) The role of religion and ethnicity in the help seeking of family caregivers of elders with Alzheimer's disease and related disorders. *Journal of Cross-cultural Gerontology* **14**, 335–356.

Lindeman MA, Taylor KA, Kuipers P, Stothers K and Piper K (2012) 'We don't have anyone with dementia here': a case for better intersectoral collaboration for remote indigenous clients with dementia. *Australian Journal of Rural Health* **20**, 190–194.

Lloyd J, Patterson T and Muers J (2016) The positive aspects of caregiving in dementia: a critical review of the qualitative literature. *Dementia* **15**, 1534–1561.

Losada A, Márquez-González M, Knight BG, Yanguas J, Sayegh P and Romero-Moreno R (2010) Psychosocial factors and caregivers' distress: effects of familism and dysfunctional thoughts. *Aging and Mental Health* **14**, 193–202.

Nadolu B, Nadolu ID and Asay SM (2007) Family strengths in Romania. *Marriage and Family Review* **41**, 419–446. doi: 10.1300/J002v4n03_09.

National Institute of Statistics (2011) Census of Population and Housing in Romania. Retrieved from http://www.recensamantromania.ro/en/.

Pinquart M and Sörensen S (2003) Difference between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychology and Aging* **18**, 250–267.

Powers SM and Whitlatch CJ (2016) Measuring cultural justifications for caregiving in African American and White caregivers. *Dementia* **15**, 629–645.

Qureshi A (2005) Dialogical relationship and cultural imagination: a hermeneutic approach to intercultural psychotherapy. *American Journal of Psychotherapy* **59**, 119–135.

Rada C (2014) Intergenerational family support in Romania. *Revista de Psihologie* **60**, 293–303. Retrieved from http://revistadepsihologie.ipsihologie.ro/images/revista_de psihologie/Rev.-Psihol.-4-2014.pdf.

Radford K, Mack HA, Robertson H, Draper B, Chalkley S, Daylight G, Cumming R, Bennett H, Jackson Pulver L and Broe GA (2014) The Koori growing old well study: investigating aging and dementia in urban Aboriginal Australians. *International Psychogeriatrics* **26**, 1033–1043.

Reid CE, Moss S and Hyman G (2005) Caregiver reciprocity: the effect of reciprocity, carer self-esteem and motivation on the experience of caregiver burden. *Australian Journal of Psychology* **57**, 186–196.

Roth DL, Dilworth-Anderson P, Huang J, Gross AL and Gitlin LN (2015) Positive aspects of family caregiving for dementia: differential item functioning by race. *Journals of Gerontology: Series B* **70**, 813–819. doi: 10.1093/geronb/gbv034.

Schulz R and Beach SR (1999) Caregiving as a risk factor for mortality: the caregiver health effects study. *JAMA: The Journal of the American Medical Association* **282**, 2215–2219. doi: 10.1001/jama.282.23.2215.

Schulz R, O'Brien AT, Bookwala J and Fleissner K (1995) Psychiatric and physical morbidity effects of dementia caregiving: prevalence, correlates, and causes. *The Gerontologist* **35**, 771–791. doi: 10.1093/geront/35.6.771.

Smith K, Flicker L, Lautenschlager NT, Almeida OP, Atkinson D, Dwyer A and LoGiudice D (2008) High prevalence of dementia and cognitive impairment in Indigenous Australians. *Neurology* **71**, 1470–1473.

Tang WK and Chan CYJ (2015) Effects of psychosocial interventions on self-efficacy of dementia caregivers: a review. *International Journal of Geriatric Psychiatry* **31**, 475–493.

Torres S (2019) *Ethnicity and old age: Expanding our imagination*. Bristol, UK: Policy Press.

Vitaliano PP, Zhang J and Scanlan JM (2003) Is caregiving hazardous to one's physical health? A meta-analysis. *Psychological Bulletin* **129**, 946–972.

Willis R (2012) Individualism, collectivism and ethnic identity: cultural assumptions in accounting for caregiving behaviour in Britain. *Journal of Cross-cultural Gerontology* **27**, 201–216.

Zimmer Z, Rada C and Stoica CA (2014) Migration, location and provision of support to older parents: the case of Romania. *Journal of Population Ageing* **7**, 161–184. doi: 10.1007/s12062-014-9101-z.

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