Characteristics of Strong Commitments to Intergenerational Family Care of Older Adults

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Objectives. The purpose of this research was to describe the characteristics of strong commitment to home-based elder care among intergenerational family caregivers.

Methods. I conducted two qualitative studies using in-depth interviews with primary and secondary intergenerational caregivers. A total of 45 primary caregivers, 10 spouses, and 11 adult grandchildren discussed development of their relative’s care, their caregiving experiences, use of paid services, and how caregiving affected their lives. I followed McCracken’s five-step method for analysis of long interviews.

Results. Strongly committed caregivers composed half of the total sample. All primary caregivers with strong commitments were women; some strongly committed secondary caregivers were men. Strong commitments had moral, religious, and affectionate bases. Participants gave compassionate care and reframed adverse situations as manageable challenges. Family members and paid providers assisted primary caregivers. Participants viewed caregiving as rewarding and as an opportunity to teach compassion to children.

Discussion. Results suggest that strongly committed intergenerational caregivers need support from both family and formal care services to sustain their commitments to care. Future research can investigate the role of resilience in caregiver commitments and develop caregiver commitment measures for use in elaborating models of informal long-term care.
a hierarchy of identities to which persons attach salience. Stryker (1991) contended that more salient identities are characterized by more commitment to the roles and relationships that invoke those identities. Social network theory contributes the ideas that specific commitments exist in systems of relationships, and that formation and negation of commitments occur in the context of one's connections to a network of others. Leik and colleagues summarized by defining interpersonal commitment as “a readiness to act consistently in the interest of maintaining a relationship with one or more others, and those aspects of personal identity that derive from that relationship for an indefinite future” (pp. 240–241). Lydon (1999) asserted that interpersonal commitments are best understood with knowledge of their relationship to adversity. He posited that when faced with adversity, committed individuals generally appraise threats as challenges.

**METHODS**

To answer the research questions, I used data from two qualitative studies in which primary caregivers were adult children, children-in-law, grandchildren, or nieces. The use of two samples from different regions of the United States, recruited from different types of sources, (a) allowed exploration of caregiver commitment among groups with differing religious and social backgrounds and (b) increased sample size. The first study examined the diverse ways in which family care at home was provided from the perspectives of younger generation caregivers, their spouses, and adult children. The second study’s primary purpose was to explore provision and financing of home care for dependent elderly family members. In both studies, I queried caregivers about how caregiving began, length of care provision, assistance with caregiving tasks, and interpersonal consequences of caregiving.

**Sample and Recruitment**

Inclusion criteria for the first study were a care recipient aged 65 or older in need of assistance with at least one instrumental activity of daily living or basic activity of daily living, with assistance provided in a noninstitutional setting at least 3 months prior to the study. In the second study, the care recipient was aged 65 or older, received primary care at home, and received paid assistance such as home health care or adult day services once or more weekly for at least 3 months. To be considered a strongly committed caregiver, one had to have been providing hands-on care for at least 6 months. I did not include in the analysis of strongly committed caregivers those who functioned solely as care managers, hiring others to provide hands-on care around the clock, and those who placed relatives in assisted living facilities because they were not providing direct care in a home setting.

Both studies sought a purposeful nonrandom sample of caregivers and families selected because of their ability to inform the research problem (Creswell, 2007). Both studies used a sampling strategy of maximum variation, in which researchers search for common patterns in cases with diverse contexts (Miles & Huberman, 1994). In the first study, agencies and ministers serving older adults in South Carolina referred participants. In the second study, two Area Agencies on Aging and a senior center in Utah made referrals. Undergraduate students at my university referred additional participants. Referrals were screened by telephone to ensure that they met the study criteria and were willing to participate.

In the first study, I interviewed 15 primary caregivers, 10 spouses, and 11 adult grandchildren. Care recipients averaged 85 years of age, the middle generation averaged 56 years, and grandchildren averaged 33 years. In the second study, 30 intergenerational caregivers were interviewed twice; their average age was 52. The group included 20 daughters, 7 daughters-in-law, 1 son, 1 stepdaughter, and 1 person caring for her husband’s aunt. Care recipients’ average age was 84 years. Care recipients in the second study received publicly or privately funded community services. Most care recipients had health problems such as stroke, Parkinson’s disease, or heart conditions that had led to multiple activity of daily living limitations; a third had symptomatic or diagnosed dementia. Most coresided with primary caregivers.

**Data Collection and Analysis**

For the most part, participants were interviewed individually, but a few included their spouses. Interviews occurred in a place convenient to participants, usually their homes. I conducted all interviews in the first study. Four trained graduate assistants and I conducted the interviews in the second study. Both studies used a semistructured interview protocol with probes for additional information. We asked all caregivers in both studies the following questions: What led to your relative’s need for care? What are your current caregiving arrangements? How has caregiving affected your relationships with the care recipient and other family members? and What are your beliefs about how to best care for older family members? Interviews lasted from 45 to 120 min and were audiotaped and transcribed verbatim for analysis.

Because the sample characteristics and the general caregiving questions asked of both groups were very similar, I combined data from both groups for analysis. I used McCracken’s (1988) multistage process for analysis of long interviews to analyze data. Initially, I read each interview transcript twice for content understanding and identification of useful observations. Next I developed observations into preliminary descriptive and interpretive categories based on evidence from the transcripts and the extant literature. Then I thoroughly examined these preliminary codes to identify connections and develop pattern codes. Next I used clusters of respondent comments and my analytic memos to identify basic themes. Finally, I examined all interviews to delineate predominant themes. At all stages of the process, research assistants reviewed and discussed the evolving coding scheme and data interpretations with me. I used the computer software program QSR NUD*IST Version 6 (QSR International, 2005) for data management and analysis.

**RESULTS**

Although caregivers in both samples exhibited some degree of commitment to caregiving, those with strong commitments composed half of both samples. All primary caregivers with strong commitments were women; some secondary caregivers with strong commitments were men. Overall, 48% of primary caregivers with strong commitments were employed in the paid labor force. A total of 57% of strongly committed primary
Characteristics of Strong Commitments to Care

Moral and religious bases.—Moral and religious bases for care are found in the writings of religious philosophers and theologians. For example, Niebuhr (1963) described the responsible self as a social, accountable person with trust in a living God, responding fittingly to the created worth of others. Among strongly committed intergenerational caregivers, providing assistance was a moral decision, often rooted in religious convictions. A daughter remarked, “I just considered it the moral thing to do. The only reason I had to do it was selfishness and that didn’t seem to be reason enough. I didn’t want to be that kind of person.” A granddaughter primary caregiver stated, “I believe that we’re to honor our parents and our grandparents, and in caring for them, we’re honoring them.”

Several daughters-in-law also felt a moral commitment to care. One remarked:

It’s our duty as human beings to fill special needs for each other. We try to be very sensitive to what she [mother-in-law] has indicated were her fears and concerns about aging. Mainly, we feel like it is the right thing to do.

Closely aligned with a moral or religious basis for care provision was the belief that family care is best for older family members. A woman who was a certified nursing assistant and was caring for her spouse’s aunt described how the aunt came to live with her family:

They put Eloise [pseudonym] in a nursing home. I tried to fight it through my husband. I couldn’t really say much. And when there were some concerns with the family about her treatment, then I stepped in and offered, “Have you ever considered letting me take care of her in my home where she can be around family?” I have five children that she adores, and I just felt like it would be an ideal situation for both of us.

Embracing the caregiver identity.—All strongly committed caregivers had internalized the caregiver identity. There were different sources of this internalization process. Some had internalized moral or religious precepts taught to them as children. A daughter who had removed her stroke-impaired mother from a nursing home to care for her at home exemplified these caregivers:

Some people are more giving toward others, more “other” oriented, and some are more “self” oriented. And I think I was born “other” oriented. I have to say that my father really influenced that. Since my parents were missionaries, he taught us that we should always be doing for other people. That was his focus.

With her spouse, she had fostered many children over the years, adopting five of them.

Several caregivers pointed to their prior caregiving experiences. One daughter said, “It has always been kind of a gift for me. It just seems to come naturally. I guess it is just being a mom, it is just a natural instinct.”

Experiences in caring professions also shaped strong caregiver identities. A nurse with a widowed mother-in-law living at home with dementia was primary family caregiver, keeping close watch on paid providers, consulting with her brother and sisters-in-law, and providing hands-on care as needed. She gave several reasons for her strong care provision:

I love this lady and this family, and I’ve oftentimes said I would just step back. I say to my husband, “I’ll just play a low profile,” but I guess it’s not my nature. I like to be involved. I said, “Jim [spouse] I love your mother, and somebody needs to do this, she needs the care.”

Affection for the care recipient.—Affection for the care recipient was prevalent among strongly committed caregivers. One caregiver described her feelings for her grandparents as follows: “I love them . . . I don’t know what I’d do with myself if something happened to them, how I’d fill my days. I’d probably miss the phone calls at 9 o’clock at night.”

A daughter providing daily care to her dementia-diagnosed mother described a nightly ritual of putting her to bed: “I’ll kiss her and I’ll say, ‘You sleep good now,’ and sometimes we’ll have a prayer together and I tell her, ‘I love you.’ She’ll say, ‘I love you oh so much.’”

Ability to provide compassionate care.—Most strongly committed caregivers expressed compassion for their loved ones. They were open and receptive to their plight, treated them with respect, and had the ability to be present in their situations (Underwood, 2002). Sometimes compassion was the catalyst for offering assistance, as in the case of a daughter-in-law, who described her decision to care for her mother-in-law as follows:

I can remember exactly when it came to me. I was sitting by her bedside, and I could tell that she was really sick. It scared me for her and I remember just putting my arms around her, and it just came to me that I’m really willing to take care of her and see her finish the rest of her life. I just didn’t want her to be alone anymore.

Providing compassionate care meant being sensitive to the older adult’s feelings about assistance. Caregivers preserved their relatives’ dignity by putting themselves in the elder’s place and “cutting down on their embarrassment and confusion.” A 54-year-old daughter-in-law caregiver said:

I find it very important that you let them maintain their dignity, and even though now she’s so forgetful and repeats herself, you think, this isn’t the mother-in-law I used to know, and you don’t want to do anything to hurt her feelings. You just have to think now if that were me—maybe it will be someday. You just have to be kind, try to be patient.
A daughter who helped her mother with personal care observed:

I have a lot of empathy thinking how would I feel if someone had to do these things for me, things that are private. That can’t be easy for anybody because she knows ... she’s the same person that she was, her body has gotten older, but that spirit is just the same.

Lastly, a 24-year-old grandson who shared the care of his coresident grandmother with his parents expressed compassion that stemmed from caring for his grandmother. He said:

Be patient, listen to what older people have to say ‘cause they’re wiser than you are. They’ve had more experiences than you’ve had. Be sensitive to them because you don’t really know what it’s like. They may be old, but they still like to have a good time. Just treat them like you would treat anybody else, and how you would want to be treated.

Daughters-in-Law as Primary Caregivers

Nearly a third of strongly committed primary caregivers were daughters-in-law who shared similar characteristics to blood kin caregivers. Data suggested two factors by which their commitment was sustained: strong spousal support, and caregiver ability to overcome reluctance to direct in-law care.

Spousal support.—Spousal support was important to these daughters-in-law, all of whom were in long-term marriages. A caregiver remarked of her spouse:

Once in a while he’ll say, “Billie, I just don’t know what we’d all do if you weren’t here to do this for mother, and I feel bad you have to be the one to take care of her.” But I think it’s brought us closer because he’s never seemed to resent what I’ve done. He seems to be appreciative of it.

Sons also expressed appreciation for their wives’ commitment to care for their mothers. Most of them relied on their wives to provide the majority of daily care. Of his wife’s care for his mother with dementia, a son who traveled extensively on business said:

I certainly have a deep appreciation of what she is contributing to all of this. It doesn’t surprise me at all, she’s always been that way, but certainly she’s really come through, and I know that it’s not easy all the time. I think she’s telling the truth when she says it’s not that burdensome, but still, it’s not her mother.

Overcoming difficulties in caring for in-laws.—Several daughters-in-law felt uncomfortable telling their mother- or fathers-in-law what to do. However, they overcome their reluctance, as noted by one caregiver who felt closer to her mother-in-law as a result of caring for her. “I also have had to take a stand and tell her no on things when I think it is a danger for her. I don’t think any daughter-in-law would like to be in that position.”

Another daughter-in-law caring for both her mother- and father-in-law noted that her role as caregiver had changed their relationships because of her insistence on her relatives’ good hygiene. She remarked:

Our relationship is more businesslike than it used to be. If I looked at things from a real loving viewpoint, then I almost couldn’t force someone to do what they don’t want to do. You almost have to separate yourself from it, and say, “I’m sorry, this is the way it is, and this is what you have to do.”

How Strongly Committed Caregivers Handle Adversity and View Caregiving

Strongly committed intergenerational caregivers found ways to sustain their commitment to care. They did so by accepting their situations and making adjustments, by obtaining family member assistance with care tasks, and by using formal care services. When necessary, they altered their own lifestyles to meet their relatives’ needs. They viewed their caring efforts as personal and family growth experiences, even when stressful.

Accepting the situation and making adjustments.—Caregivers felt stresses associated with caregiving and talked frankly about the lifestyle changes their commitments entailed. A daughter-in-law remarked:

You have to realize that you go with the flow of life as it’s there at the time. Don’t plan the future too terribly much or moan over what happened yesterday because for this person [care recipient], it’s just right now. Some days you are not going anywhere. You are staying home all day. If you have that acceptance, it’s very calming to them [elders].

One daughter described her adjustment to caring for her mother with dementia as follows:

You fight and scream and kick all the way; you don’t want it. “I want my mother back!” But after awhile you learn to cope with your situation, and you learn to laugh to keep from crying—and she says some very funny things. Sometimes we get tickled at her.

In the second sample, caregivers were asked how they would respond if the state-funded services currently provided by state and local agencies were no longer available to them. Those with strong commitments to home-based care offered a variety of solutions. For example, one daughter with a mother in adult day care said:

I guess my brother and I would pay for it and [have her] try to go fewer days. I know that my brother and I would do whatever we needed to do so that she would be taken care of. I would see if there were other agencies. There are always things out there that you don’t know about that you can get help from.

Family is supportive.—Another way in which caregivers met adversity was through the assistance of family, usually spouses and children. One daughter-in-law caregiver said of her husband, “He’s a good support to me when he’s needed, he’s there to help.” Later she noted that he had become more supportive over time, a situation echoed by several caregivers:

Sometimes he resented the time that I needed to spend in the caregiving. When I would talk to him about my frustrations, he would want to solve all the problems. I didn’t need things to change; I just needed to talk about it. I think he understands that better now. He lets me just talk ... in that way, our relationship is stronger.
Children also were helpful, sometimes more so than siblings or in-laws. When asked about her children’s involvement in her parents’ care, one caregiver daughter said:

They stay with Grandma and Grandpa, or they fix meals. If I need to go somewhere, they will be here. And it isn’t like it is a grudge thing. My children all know how to do Grandma’s medicine, and they could change her. So it has never been a question with my kids if they would help. It was just, “What do we need to do?”

Receiving formal care services.—Most participants, particularly employed caregivers, were currently using formal or paid care services. Although not always pleased with the quality of services provided, most viewed them as an integral part of their care provision. For example, a daughter who worked full time and used adult day services for her mother with dementia said:

They are wonderful; they provide the bus service [to day care]. Like I said, we were concerned about her getting up so early, she was fighting me, and I said, “Is there any way she can come later?” They were actually sending a car out just for her later in the morning like around 10:00. They were really going the extra mile.

Another daughter noted that her father made better progress after hip surgery when physical therapists came to their home to work with him: “He had them the normal length of time that they were needed. He was doing okay. But when they stopped coming in, we would slack off because we would get busy with life, instead of concentrating on that.”

Caregiving is a growth experience.—Strongly committed caregivers described personal or relationship growth as benefits of their care provision. Some cited an increased love for their relatives, whereas others cited improvement in personal attributes. A daughter-in-law said, “So our relationship together was there.”

Caregivers also emphasized their lifestyle restrictions. A daughter who cared for a bedridden mother explained:

When you take care of someone, I think you learn to love them more. You learn to care about them, about all kinds of things more. I am finding that before [I cared for my father] there were things that would bug me about her [mother]. Now it is more me caring about those things than letting them bug me.

Another daughter said:

One of the biggest lessons this has taught me is patience, to be patient, and also to be able to handle things. A few years ago when there would be problems with mom, I would get a lot more nervous and upset, and now it seems like it’s easier for me to handle it.

Additionally, several caregivers mentioned the opportunities for growth that caring for grandparents had offered their children. The participant caring for her husband’s aunt illustrated this effect:

They are learning a lot of important skills with compassion and service and love for elderly people. It is a beautiful thing to see take place. They are learning to be more selfless, and in today’s world that is really important. It is really needed.

A 30-year-old granddaughter who assisted her mother with the care of her grandmother and aunt talked about what this care provision meant to her:

It means helping my mom, with some of her duties, and also just giving some love and affection to my loved ones. I just . . . I like it. I just love spending time with them, hugging and kissing them, and saying their prayers with them.

Caregivers With Weaker Commitments to Intergenerational Care

A major difference between those with strong commitments to care and other caregivers lies in the notion that caring provides the caregiver with self-esteem, meaning, and purpose. Those with weaker commitments to care did not see caregiving as enhancing self-esteem or providing them with a sense of purpose. Instead, they expressed ambivalent feelings about caregiving, often struggling with its stressful aspects. Most felt only duty or obligation to care for their elderly relatives. For example, a daughter said, “I do it because she’s my mother. I do it because my daddy would want me to, and my daddy was my heart. Mamma and I never were close.” Some relationships with care recipients were difficult or lacked affection. A daughter-in-law who had “inherited” her father-in-law’s care said of him, “It’s just frustrating sometimes, he can be so childlike and I already have a teenager and I don’t need two. She’s 14 and he’s at the same level at [age] 84 of stubbornness.”

Caregivers also emphasized their lifestyle restrictions. A daughter who cared for a bedridden mother explained:

My children are jealous of it because I cannot go and do with them. Everything is done here. We don’t go to the beach like we used to; everything has to be done on the back patio. They think that it’s wearing me out, that it’s time to put her in a nursing home.

In a follow-up call, she revealed that she had placed her mother in a nursing home a week after our interview.

Finally, for many of these caregivers, family relations were strained, especially with siblings. Of her brother-in-law one woman said, “It has very much distanced us from the one that is least involved, because there are some things he has done that we felt were undermining. So it has really severed what relationship was there.”

Discussion

Guided by interpersonal commitment theory, I have described the components of strong caregiver commitments to parents, in-laws, grandparents, and other elderly family members. Results suggested that many intergenerational caregivers had strong commitments to home care provision and maintained their commitments despite competing responsibilities and difficult care demands.

For these caregivers, commitments to care had moral and religious bases that extended beyond notions of duty or obligation. They felt genuine affection for the care recipient. Many of them described being a caregiver as a highly salient identity. Identities with high salience produce greater commitments to roles invoking those identities (Stryker, 1991).
Strongly committed caregivers responded to their moral or religious convictions by providing compassionate care, adjusting their routines, and accepting their changed lifestyles to accommodate care provision. In so doing, they exhibited a “moral imagination” (Black, 2004), the ability to reflect on themselves and others, do what they felt was best for elders, and view their care provision as a process of growth in competence and compassion. These caregivers often reframed the stressful aspects of caregiving as opportunities for personal and relationship growth, frequently involving their children in care tasks so that they too would learn values of compassion and sacrifice. Their systems of care tended to reflect collectivist orientations (Pyke & Bengtson, 1996), in which family assumes the care of frail elders, eschewing nursing home placement under most conditions.

However, providing compassionate care and altering lifestyles did not preclude recognition of self-care needs. Strongly committed caregivers sought both instrumental and emotional support from family and, in many cases, formal care services. In so doing, these caregivers may have lessened feelings of subjective burden and role captivity, both of which can precipitate institutionalization of elders (Gaugler et al., 2000; McFall & Miller, 1992). Using services also may have increased their competence as caregivers. In a study of the meaning of quality home care services, Piercy and Dunkley (2004) found that family caregivers viewed good-quality formal services as enhancing the quality of life for care recipients and teaching them skills that improved their performance in the caregiver role.

Findings from this study suggest that researchers can extend interpersonal commitment theory beyond couple relationships to explain commitment to intergenerational caregiving relationships, particularly in the area of adversity. Adversity in intergenerational care stems from the care recipient’s condition, caregiver standing as an in-law, and structural conditions such as paid employment. As the care recipient’s health deteriorates, caregivers are challenged to maintain elder safety while maintaining a workable alliance with them. Simultaneously, caregivers must meet responsibilities to self, family members, and employers. Strongly committed caregivers in this study showed that marshaling personal, familial, and formal care resources kept adversity at manageable levels.

Daughter-in-law care provision was sustained by spousal support and caregiver willingness to overcome discomfort about directing in-law care. Studies of in-law caregiving are few (Globerman, 1996; Suitor & Pillemer, 1994). Like the present study, Globerman found that daughter-in-law caregivers were persons who took charge and “did what had to be done” (p. 40). However, in contrast to Globerman’s findings, some daughters-in-law in the present study felt deep, long-lasting affection for their in-laws.

Providing parent or in-law care can affect marriage, too. Suitor and Pillemer (1994) found that providing dementia care altered the marital satisfaction of some daughters and daughters-in-law over time, with husbands’ increased emotional support and decreased hindrance associated with increased marital satisfaction. Although the present study did not measure marital satisfaction, findings suggest that a spouse’s emotional support of his wife’s caregiving helps sustain her commitment to care and oftentimes fosters closeness to each other. Research has shown perceived spousal support to benefit marriage by maintaining emotional contact and increasing intimacy in couples (Cutrona, 1996).

The concept of resilience also may be useful in understanding strong caregiver commitment to home care. In longitudinal study of dementia caregivers, Gaugler, Kane, and Newcomer (2007) found that resilient caregivers were less likely to institutionalize their relatives over a 3-year period than less resilient caregivers. Bergeman and Wallace (1999) cited self-concept, perceptions of control and self-efficacy, and hardiness as personal factors that may improve resilience. They argued that being hardy influences interpretation of situations as stressful or nonstressful. Hardiness also may prompt people to cope with stressful events in imaginative ways (Maddi, 2002). Caregivers in this study exhibited creative ways of dealing with adversity in order to continue home care provision. Their families also may have possessed resilient traits. Walsh (1996) suggested that interaction processes such as organization, communication, and problem solving over time strengthen both individual and family hardiness. However, the exact relationship between resilience and commitment to care needs longitudinal study. Being resilient may be necessary to making a strong commitment to provide home care, or it may be that caregivers and their families increase resilience as they adapt to changing care circumstances, such as the physical or cognitive decline of the care recipient.

Findings suggest that strongly committed intergenerational caregivers resist ceding their caregiver roles unless changing personal or family circumstances reduce salience of the caregiver identity. However, with reduced family sizes and the increasing participation of middle-class women in the paid labor force, scholars have questioned whether society is asking too much of families (Hooymann & Gonyea, 1995; Montgomery & Williams, 2001), particularly women, to provide long-term care at home. Current policy assumes the presence of nuclear families with female members readily available to provide elder care. Such policy flies in the face of current family trends, leading to unmet needs in community services for dependent elders (Desai, Lenzner, & Weeks, 2001). This study’s findings suggest that formal care services are critically important to sustaining strong commitments to home care among intergenerational caregivers. Policy makers must address expansion of these services and appropriate compensation for workers because high turnover rates are a serious problem, especially among paraprofessionals (Feldman, 1993; Kaye, Chapman, Newcomer, & Harrington, 2006; Montgomery & Williams, 2001).

Study Limitations
Several limitations to this work are worth noting. First, most caregivers in both studies were from middle-class families, which likely increased their ability to commit substantial resources to caregiving. However, with nearly half of these caregivers in the paid labor force, employment did not preclude strong commitment to home care. Second, the study’s findings are cross-sectional, so the full length of time that participants sustained commitment to home care is unknown, as is whether caregivers achieved their intentions to prevent institutionalization. Additionally, most caregivers were married, were Caucasian, and possessed strong religious backgrounds. Studies
with samples more diverse in marital status, religiosity, and ethnicity are needed to see if characteristics of strong commitments to care are similar for these individuals.

Conclusion

Illumination of the characteristics of strong intergenerational commitments to care for frail elderly family members has suggested that individuals, caregiver-care recipient dyads, family systems, and social service systems often combine to generate and sustain these commitments. Additional study of the characteristics of strong commitment to maintaining long-term care at home could prompt research focused on the measurement of these characteristics for use in models of informal long-term care, as well as in studies that examine links between caregiver commitment and caregiver and care recipient outcomes.

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