Factors that Impact Chinese Canadian Family Carers' Intention to Use Long-Term Care Facilities and Home Support Services

by

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ABSTRACT

The demography of Canada has been changing dramatically, and a rapidly growing population of aging Chinese Canadians poses unprecedented challenges to the health care system. Understanding the service needs of Chinese Canadian seniors will grow in importance. Chinese tradition values filial piety which can pose challenges for the decision-making process of Chinese Canadian family carers in relation to nursing home placement of a loved one. Guided by Andersen's Behavioral Model, this researcher endeavored to measure the relationships between Predisposing factors (i.e., demographic information, filial piety attitudes), Enabling factors (i.e., family carer's ability, willingness to access health services, and their regular source of care), and Need (i.e., the level of carer burden) and family carers' intention to use health services. A quantitative design was employed to explore and identify factors that influence family carers' intention to use health services and long term care for their parent. Data collection for this study occurred over one-month period from September, 2019 to Octomber, 2019 in Winnipeg. Quantitative findings suggested that only the predisposing factor of carer gender was significantly correlated with the carer's decision to institutionalize their parents. More specifically, female Chinese Canadian family carers were less likely to use a long-term care facility. A borderline significant relationship (Predisposing factor) ($p < 0.1$) was found between the carer relationship to the care recipient and use of a long-term care facility. Content analysis revealed that social support, language barriers, cultural expectations, and finances all played an important role as barriers or facilitators in family carers' decision-making process. This study's findings have several important implications for nursing practice.

Keywords: Chinese Canadian family carer, Andersen’s Behavioral Model, long-term care, gender

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DEDICATION

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STATEMENT OF THE PROBLEM

Introduction

Worldwide populations are aging and people are living longer (World Health Organization [WHO], 2015). In tandem with this trend, we are seeing people having fewer children that impacts the availability of family members to meet the needs of aging loved ones. Due to the expected decline in the availability of caregiving families, meeting the service needs of unpaid informal carers is becoming increasingly salient (WHO, 2015). Canada, like much of the developed world, has an aging population. Over the next 10 years, 5.1 million Canadians will reach the age of 65 years that requires the attention of federal and provincial governments to meet the care needs of an aging population (The Conference Board of Canada, 2018).

In 2013, 8.1 million Canadians or 28% of the population aged 15 years or over provided care to family members or friends with a long-term health condition, a disability or problems associated with aging. Informal carers are unpaid carers who provide critical support and care that allows loved ones to recover from illness or to deal with aging at home (Statistics Canada, 2015). Among these family carers, 39% primarily cared for their father or mother (Statistics Canada, 2015). Fifty percent of carers are between the ages of 45 to 65 years. Seventy to eighty percent of community care for older adults is provided by carers (Carers Canada, 2018). According to Home Health Care Agencies (HHCA, 2010), receiving care at home is often considered a desirable option for Canadians requiring chronic, palliative or rehabilitative care.

Many times this is because individuals feel more at ease in familiar surroundings and are able to maintain some sense of independence in their own home. In a way, the biggest advantage of in-home care for seniors is that it allows older adults to age in place and avoid making the move to costly long-term care institutions. Therefore, family carers have become an important part of the health care system by providing support and assistance needed by the aging population.

According to the 2016 Census, 7,540,830 people represented 21.9% of the Canadian population as immigrants (Statistics Canada, 2017). Among the immigrants whose mother tongue is other than English or French, Chinese languages are most common. A total of about 852,700 individuals reported speaking Chinese languages (Statistics Canada, 2018). With an increased number of immigrants from China who are also living longer, there is an increased number of persons requiring culturally competent formal care (nursing home) and informal care (care at home).

According to Chinese tradition, older parents are taken care of at home by their families. Heavily influenced by Confucianism for centuries, Chinese society has taken for granted that adult children take care of their old and sick parents. However, major changes in modern society have produced radical alterations in traditional thoughts and the function of Chinese families in recent decades that has placed families in a complex decision-making position regarding family caregiving. In addition to societal changes, complex problems associated with immigration and living in a western world have made the caregiver role even more problematic for the family carers. However, to date, there has been a paucity of empirical endeavours that have examined decision-making issues experienced by a significant segment of Canada’s caregiver population;

i.e., Chinese Canadian family carers about the long-term care and support of their aging loved ones. Therefore, this researcher believes that it is important to explore the decision-making processes of Chinese Canadian family carers as influenced by the Chinese culture. This study finding will be helpful to nurses in their provision of culturally competent care to aging patients and their caregiving families and decision-making about long-term care.

Purpose of the Study

The purpose of this study was to examine Chinese Canadian family carers' experiences with filial piety and decision-making about long-term care and home care services for their aging parents. Guided by Andersen's Behavioral Model (Andersen,1995), this researcher endeavored to measure the relationships between predisposing factors (i.e., demographic information, filial piety, attitudes), enabling factors (i.e., family carer's ability to care and willingness to access health services), and need factors (i.e., the number of health conditions of the care recipient and the level of carer burden) and family carers' intention to use health services. Two supplementary open-ended questions were asked to further explore the Chinese Canadian family carer's perception of what facilitates or hinders their caregiving and decision-making processes.

Research Question

The researcher will answer the following research question:

What is the association of predisposing characteristics (e.g., demographic characteristics, filial piety), enabling resources (e.g., access to health services) and need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making processes about long-term care?

Of note, although this researcher was guided by Andersen's Behavioral Model (Andersen (1995), no hypotheses of relationships were posed due to limited research being done in Canada in this area. This researcher approached this as an exploratory study without posing hypotheses.

Research Design

The research designed to be a predictive study aimed at exploring factors that influence Chinese Canadian family carers' intention to use health services and long-term care for their parent. Participants will be recruited from the target population of Chinese Canadians living in Winnipeg, Manitoba, Canada. A quantitative design was employed to explore and identify factors that influence family carers' intention to use health services and long term care for their parent.

Definition of Terms

To facilitate understanding of terms employed in this study, the following are definitions for each term:

Family Carer

A carer (also referred to as a caregiver or family caregiver) is a person who takes on an unpaid caregiving role for someone who needs help because of a physical or cognitive condition, an injury or a chronic life-limiting illness (Carers Canada, 2018)

Long-term Care

Long-term care involves a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own (National Institute on Aging, 2017). In Winnipeg, there are several options available as long-term care, including: chronic care, companion care, personal care homes, respite care, and supportive housing (Winnipeg Regional Health Authority [WRHA], 2019).

Personal Care Homes

According to the WRHA (2019), a personal care home (PCH) provides personal care services to individuals who can no longer manage independently at home with family support and/or community services, such as home care, and where other assisted and supportive housing options are not suitable.

Filial Piety

Filial piety is a cornerstone in Confucian Heritage Societies. It is defined as an authoritarian relationship that requires children's absolute submission to parents' wishes, as well as their duties to repay parents' sacrifices, preserve family honor and continue the ancestral line (Lum, et al., 2016).

Significance of the Study

In Canada, the Chinese Canadian population is rapidly growing. A large section of the Canadian population is comprised of Chinese Canadian family carers who are providing support and care to their aging loved ones. Filial piety is a concept that can play a large influence on the decision-making processes of Chinese Canadian family carers about the long-term care of their loved ones. To date, however, there is limited empirical information about how clinicians can provide culturally competent to care to this specific family carer population in their provision of care and in making decisions about ongoing supports for their older relatives.

In recent decades, there has been a growing shift away from institutional forms of care for Canadians with chronic health conditions or aging needs to an increased reliance on care within the home (Keefe et al., 2006). The emphasis on family caregiving has accompanied changes in Canada's age structure, with seniors representing a growing segment of the population (Statistics Canada, 2015). With a growing Chinese Canadian population of older adults, it is important for researchers to engage in a systematic exploration and capture of the decision-making processes of Chinese Canadian family carers as influenced by the Chinese culture. This study will provide valuable insights to health care workers, policy makers, and researchers on caregiving and practice of filial piety among Chinese community members in Canada. Nurses will be helped to better understand filial piety belief and caregiving practices among Chinese Canadian family carers and to provide culturally sensitive approach in supporting adult children carers in their decision-making processes about long-term care of aging relatives.

Summary

In summary, this introductory chapter has provided background information about the significance of the problem and described the purpose of the study, the research questions, the research design, definitions for the key terms utilized throughout, and the significance of the study. The following chapter will review the current literature and identify the key concepts being addressed in this study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

To facilitate this researcher's understanding of the current state of the science in this area of research, a literature review was conducted. The social context of the Chinese Canadian family carer experience and decision-making processes about elder care were the focus of this literature review. The first section describes the social context of caregiving in Canada inclusive of statistics and the importance of the caregiving role to care recipients. The second section reviews the social context of being a Chinese family carer and cultural factors that potentially influence the Chinese Canadian carer's decision-making process about elder care. The third section will focus on the decision-making process on elder care by Chinese Canadian carers. The fourth section will describe the nurse role in supporting the carer-care recipient decision-making processes in the context of competent cultural care. The final section will highlight knowledge gaps that exist in comprehending decision-making processes by Chinese Canadian family carers regarding care and institutionalization of the elder care recipient.

Chinese Canadian Carers

In 2016, over 250 ethnic origins or ancestries were reported in the Canadian population (Statistics Canada, 2017). According to the 2016 Census of Population, 7.5 million foreign-born people came to Canada through the immigration process. Foreign-born people represent more than 1 in 5 persons in Canada. Among these individuals, 129,020 are from China (Statistics

Canada, 2017). Given the increasing numbers of immigrant families in Canada, it is important to consider the context of diversity in recognizing and supporting family carers from a range of cultures. The rapidly growing aging population of Chinese Canadians pose unprecedented challenges to the health care system (e.g., the provision of culturally competent care). With the increase in the Chinese Canadian elder population, one can expect an equally dramatic increase in the number of Chinese family carers. Consequently, knowledge about ethnic family carers and the barriers they face when accessing health services for their elder care recipients can help to create more inclusive policies that are culturally sensitive to meet their decision-making needs.

Use of Health Services by Chinese Canadian Care Recipients and Family Carers

According to Canadian Association of Retired Persons [CARP] (2014), by taking into consideration the number hours of care provided and market wages, the economic contribution of family carers is conservatively estimated at $25-26 billion annually. The savings to the health care system are even greater since many people who would otherwise need care provided by hospitals and other care facilities receive care at home instead. However, CARP’s (2014) report also highlighted some challenges that family carers are facing that include the loss of financial or employment well-being, a decline of mental, emotional and physical health, and the lack of formal support and training. Current federal programs are not adequately recognizing the burdens of 8 million family carers (CARP, 2014). In relation to this researcher’s thesis topic, there remains insufficient data on the needs of ethnic minority groups like Chinese Canadian family carers (CARP, 2014). Early literature indicated that despite the increase in Chinese family carers, their access to or utilization of needed community-based services number was low (Liu, 2003). A more recent survey conducted by Lai and Surood (2008) reviewed the barriers that Chinese Canadian family carers face in the caregiving role. These researchers conducted telephone interviews with 315 immigrant Chinese adults living in Calgary. Their results revealed that Chinese Canadian family carers reported an average of 6.8 (SD = 4.2) access barriers to services. The most commonly reported barriers were as follows: 61.3% reported professionals who do not speak the service user's language and 56.8% felt that professionals do not understand the Chinese culture. Individuals who are new to Canada face unique challenges because they may not be proficient in English, or have well-developed social networks that can link them to services (Facts, 2006). According to Lai and Surood (2008), culture-related barriers pose the greatest influence on newcomers' decision-making about care, as well as their timely and appropriate access to and utilization of health services. The following will describe the historical background of Chinese immigration and culture to help the reader comprehend the pattern of decision-making in elder care by Chinese Canadian family carers.

Historical Overview of Chinese Immigration and Cultural Characteristics

The Chinese Diaspora in Canada: Historical Waves of Chinese Immigration

China is a major source country for immigrants to Canada. The large numbers of Chinese immigrants in Toronto, Vancouver, Montreal, and other cities has had implications for not only their settlement and integration but also the shaping of foreign policy (Zhang, 2017). International migration among Chinese people is centuries old. The Chinese people have displayed varied immigration patterns across different periods and in different places as impacted by the Chinese state. Before 1949, most of the early emigrants from China came from coastal provinces of Guangdong and Fujian. They worked primarily in cash-crop farming (e.g., sugar, pepper, Gambier, and rubber) and in tin or gold mining (Zhou & Benton, 2017). According to Gao (2017), after World War II, the image and social standing of Chinese migrants changed by the new migration groups. Chinese emigration changed significantly in two main ways, First, between 1949 and 1979, many Chinese in Taiwan and Hong Kong chose to leave China because of wars, political turmoil, and fear of persecution at home. During this period, Chinese immigrants were mainly from Taiwan and Hong Kong. Their economic status and education levels were comparatively high, which contributed to social standing changes in China with the exodus of people. Migration from mainland China stopped after 1949 because the country was closed off from the outside world. Second, after 1979, China opened its door to the world and more and more Chinese with a diverse range of socioeconomic characteristics began to migrate to different parts of the world. Canada became a key destination. They were called “xin yimin” or the new Chinese migrants. The origins of the new immigrants are much more diverse than the previous groups as they now come from all over China. Historically, Cantonese was widely represented in Chinese immigrants, but after the 1990s, Mandarin was commonly adopted by immigrants (Gao, 2017). The new Chinese Canadian tends to be skilled and highly educated. These characteristics of Chinese Canadians today have changed the profile of this community. To date, however, most of the existing empirical studies have targeted Chinese immigrants from early years (from 1949 to 1979). Most recent Chinese Canadian immigrants are not well researched which is the target of this researcher’s thesis project.

Chinese Socio-Demographic Changes

For centuries, Chinese families embraced Confucian ideals. Families were patrilineal, patrilocal, and patriarchal which means that they are governed by rigid norms and hierarchical interactions between generations (Goh, 2011). Historically, the family size was bigger and multi-generations usually lived in one household. When it comes to decision making, parents have absolute power. Children are expected to be unconditionally respectful, obedient, and provide care for aged parents (Goh, 2011). When the Communists came to power in 1949, the traditional Confucian values were derided as hindrances to the communist belief (Goh, 2011). The Communist party enacted new family laws and regulations (such as the 1950 Marriage Law and later revisions) that aimed to reduce the power of traditional patriarchal families and promote gender equality (Goh, 2011). Mao Zedong (Chairman Mao) was the first ruler since the unification of Communist China who has had an overwhelming influence on propelling China to become a major world power. Mao believed that the larger the population, the more power the country would have to fight against capitalism (Kissinger, 2011). As a result of childbirth encouragement, the population nearly doubled over the next 25 years from 1949 to 1969 (Greenhalgh, 2005). Chinese baby boomer generation were borne in the 1950s to the 1960s. The baby boomer generation ranges in age from 60 to 70 years and comprises the biggest portion of the aging population.

By the beginning of the 1970s, the Chinese government had growing concerns regarding

China’s population growth and the effect it would have on its modernization and economic goals. By the late 1970’s, Deng Xiaoping became the leader of the China after Mao died. In 1979, the world’s most radical population policy or the one-child policy was introduced in China. All married couples were to be restricted to only one child (Deutsch, 2006). This policy has been applied within the Han ethnic group which accounts for 92% of the total Chinese population. Han is the largest single ethnic group in the world (Greenhalgh, 2005). Deng established the one-child policy in order to create a generation of “high quality” people with the resources and ambition to make China competitive in the capitalist world system (Fong, 2004). In 1970, when population control policies began, China’s total fertility rate was 5.8 births per woman; in 1980, two years after the start of the one-child policy, China’s total fertility rate was down to 2.3 births per woman (Fong, 2004). By 2016, the fertility rate in China dropped to 1.6 births per woman (The World Bank Group, 2018). This strategy has succeeded, but at a price. Heavy parental investment enabled many singletons to attain better living standards and educational opportunities. But they faced intense parental pressure and expectations (Fong, 2004). Cross-generational caregiving in Chinese families is typically structured on a reciprocal model. In this model, parents are obligated to nurture their children with the expectation that adult children will take care of elderly parents (Li & Tracy, 1999). Shrinking family size and the rapidly aging population continues to stretch the ability of families to provide support for the elderly (Li & Tracy, 1999).

Long-term Care in China

The one-child policy also created a dramatic family structure change in China. According to Zimmer and Kwong (2003), because of the decreased fertility rate that is combined with the large population segment of Chinese baby boomers, China is experiencing a rapid growth in the proportion and number of older people in its population. The aging of the population and its magnitude have implications for the support of China's older population. In 2000, there were 88,110,000 persons aged 65 years or older which represented 7% of the population (Chu & Chi, 2008). This percentage is projected to increase to 35% in 2050. The estimated aging population will peek at 487 million senior citizens in 2050 (China times, 2018). In China, because of filial piety, adult children are today viewed to be responsible for the care of their elderly parents. Only childless older adults are cared for in welfare institutions that are supported by the public sector or the government. These welfare institutions or "homes of respect for the elderly" were stigmatized prior to the 1980s. Families with adult children had no expectation to institutionalize their elderly parents (Zhan et al., 2008). However, in recent years, the reduced family size has made decreasing numbers of adult children available to provide elder care. Declines in the availability of adult children has resulted in parallel reductions in available support to elders. There is a growing gap between needed support and actual support that is provided to Chinese elders.

The decreasing fertility rate combined with a large Chinese baby boomer population has created a "4-2-1 phenomenon". This phenomenon means one child has to take care of his or her two parents and four grandparents. However, many adult children need to work a full-time that makes it nearly impossible for them to take care of their elderly relatives. Such a scenario calls for much faster and more helpful interventions from the state to ensure that levels of unmet needs by family carers and patients do not increase sharply (Zimmer & Kwong, (2003). After the welfare reform of the 1990s, many government-sponsored nursing homes have become privatized. A large number of new private and community-run nursing homes have opened for business (Zimmer & Kwong, 2003). According to Zhan, Feng, and Luo (2008), from 1950 to 1990 only six nursing homes for the elderly had been funded by the government. From 1995 to 2000, more than 300 elder care homes were established. Statistics show that as of September 2017, China has more than 144,600 nursing institutions; this number represents 226 percent more nursing institutions than what existed at the end of 2012 (China Daily, 2018). The statistics from The State Council (2016) revealed that China's senior service industry developed quickly during the past five years, and nursing home beds increased to 6.7 million at the end of 2015.

Gender and Carer Roles

According to Statistics Canada (2013) report, *Portrait of Caregivers* report, women represented a slight majority of caregivers in Canada at 54%. Women are more likely than men to spend 20 or more hours per week on caregiving tasks (17% versus 11%). Meanwhile, men are more likely than women to spend less than one hour per week providing care (29% versus 23%). The report also stated that the increased intensity of caregiving among women may be partly related to the type of task commonly performed by them. Women tend to provide care or do activities that must be completed on a regular or set schedule. Women were twice as likely as males to provide personal care to the primary care receiver, including bathing and dressing (29% versus 13%), (Statistics Canada, 2015). Lai, Luk, and Andruske (2007) found that wives are more likely to be the spousal caregivers among elderly couples. When the spouse is not available, daughters are the predominant care providers. Statistics Canada (2013) also stated that about half (48%) of carers reported caring for their own parents or parent in-law over the past year. Adult children were almost four times more likely to report caring for a parent than a parent-in-law, and two and one-half times more likely to report caring for their own mother than father. Senior women often outlive their spouses, and must then rely on their children for support with aging or health problems (Statistics Canada, 2015)

Historically, there has been a major difference in gendered care between Chinese and Western cultures. In the Chinese culture, the younger generation had to conform to the hierarchical status regulated by filial piety in order to maintain parent-child relationship harmony. This relationship harmony emphasized the male-dominated privilege. In other words, sons had often been viewed as an individual's "insurance" for old age. This viewpoint is highlighted in the old Chinese saying, "Yang Er Fang Lao" that means sons will provide caregiving when parents become old and frail (Rubinstein, 1987). However, even though men make caregiving decisions in the household, women in the home (e.g., wives, daughters, and daughters- in- law) fulfill the actual caregiving responsibilities. In fact, the daughter-in-law often has been the key care provider in traditional Chinese society. In the West, daughters are more likely to perform the primary carer role. According to Horowitz (1985), daughters are more emotionally close to their parents than sons. Daughters predominate as primary carers to their parents.

Lai, Luk, and Andruske (2007) completed a telephone survey with a random sample of 339 Chinese-Canadian carers of elderly care recipients where gender differences in caregiving was the focus. Contrary to previous studies where sons and daughters-in-law were identified as primary family carers for aging parents, Lai et al. (2007) found that daughters and wives of care recipients (versus daughters-in-law) played the primary carer role. Among all family carers, daughters were the largest group of carers in Lai et al.'s (2007) study. When Chinese Canadian women needed to make a choice between providing care to their own parents and their parents-in-law, daughters were more likely to choose to be the primary carer for their parents. Due to socialization in Western society, immigrant women may experience a change in cultural values and beliefs that may explain why daughters-in-law no longer embrace the traditional gendered caregiving role associated with their husbands who are sons of parents. Instead, many daughters are seen as primary carers for aging parents. According to Lai et al (2007), more female carers reported being married than male carers. No significant gender differences were reported in the types of caregiving tasks performed in the caregiving role. Cheung and Kwan (2009) also found that more daughters practiced filial piety than sons of care recipients. As well, married people demonstrated more filial piety practices that appeared related to having greater access to social resources.

A Canadian study by Mitchell (2014) sampled 236 parents from British, Chinese, Southern European, and South Asian Canadian cultural groups. Mitchell (2014) employed mixed-methods to explore the gendered and ethno-cultural aspects of dual generational caregiving among a sample of ethnically diverse Canadian midlife parents. This researcher found that caregiving experiences remained highly gendered where women often juggled multiple roles. Women reported greater generational demands than men. Moreover, most of the study participants reported greater generational demands to engage in caregiver tasks by aging parents. Mitchell (2014) used the term "sandwiched generation" to describe the middle-aged generation (particularly women) who are squeezed between the simultaneous demands of caring for their aging parents and their young adult children. Women have unprecedented stresses from needing to meet the demands of work and caregiving, balancing multiple identities (e.g., being a parent, friend, spouse) and responding to normative pressures to take good care of themselves. Mitchell's (2014) research focused on the carer role in different minority groups. Key findings suggested that regardless of cultural background, female versus male carers are more highly prone to greater generational demand, guilt, work-life stress, and burden. Also, some ethnic minority women may be more at risk for strain due to gendered expectations, relocations, loss of social networks, language issues, and extended family living arrangements. Study findings suggest that we need more cultural and gender-sensitive strategies to support carers in addition to enhancing male involvement in caregiving.

Filial Piety

Filial piety is a family-centered cultural construction (Zhang et al., 2015). Traditionally it had been considered the foundation for all Chinese social norms and cultural values. The traditional value of filial piety places an expectation upon the young to respect the old. It refers to the notion that the younger generation should obey the older generation and should fulfill the older generation's need for both material and emotional support at any cost and under any circumstance. Filial piety enforces unconditional loyalty and devotion to parents and family (Ma, 2006). Hsueh (2001) identified four conceptual components of filial piety that include being concerned for parental health, financially supporting parents, fulfilling the housing needs of parents, and having respect for parental authority. Practically, filial obligation means that children should ensure that their parents are well cared in their old age. It is often assumed that the enactment of filial piety through caregiving reflects attitudes and behaviors of family members (e.g., children) that are supportive of this obligation. Moreover, the attitudes and behaviors of children should be "willingly and freely practiced, not as a result of authoritarian commands or coercion" (Cheung & Kwan, 2009, p.181)

Chinese health care is grounded in filial piety. Chinese Constitution and Marriage Law stipulates that parents have the duty to rear and educate their children. In return, when children grow older they have the duty of caring for their parents. (Cook, 1986). The law of the People's Republic of China on the Protection of the Rights and Interests of the Elderly was amended in 2015. Article 14 specifically addressed that the children of the elderly or other persons who are under legal obligation to provide for the elderly "shall fulfill the obligations of providing for the elderly economically, taking care of them in daily life and comforting them mentally, and attend to their special needs" (Order No. 24 of the President of the People's Republic of China, 2015). Article 15 stipulates that the children or other supporters "shall ensure that elderly suffering from illness receive timely treatment and care, and shall pay medical expenses for the elderly in financial hardship" (Order No. 24 of the president of the People's Republic of China, 2015). Currently, the Chinese government primarily relies on family caregiving and filial piety to meet the growing number of older adult population.

However, the value of filial piety is changing with economic reformations in China. In recent decades, with economic modernization and societal changes, older children are less likely to live with their parents which reduces the opportunities for filial piety actions. Cheung and Kwan (2009) found that filial piety was lower when people were city dwellers and exposed to higher or more advanced modernization. Li and Tracy (1999) reviewed the situation in rural China and found that filial piety has lost its original meaning of absolute obedience to and sacrifice for parents. However, the ideological implication that younger generation should respect the seniors and take care of their parents remains strong in rural China where support and services from outside the family are limited.

Ma (2006) examined the practice of filial piety and its impact on long-term care policies for elderly people in Asian Chinese communities. He found that filial piety had a diminished influence but yet was still observed although not in traditional ways. Nowadays, the practice of filial piety in Asian Chinese communities is mainly confined to the satisfaction of parents' physical needs and comforts. It does not mean filial piety is no longer important. In recent years, people are adopting a more practical approach to fulfilling their duties, and long-term care service is one of those approaches. Lai (2004) found that a significant portion of aging Chinese Canadians reported they would consider applying for long-term care for their parents. Many aging Chinese also realized that they may require care that their children may not be able to provide. Therefore, Ma (2006) concluded that although the need for long-term care will rapidly increase in Asian Chinese communities, it will still be important for filial piety to be valued by Chinese Canadian carers. In other words, as long as children feel obliged to support their elderly parents and relatives, this sense of responsibility should be upheld and encouraged (Ma, 2006), even in long-term care. Ma (2006) also argued that the value of filial piety should not be over-emphasized to the extent of placing undue burden upon children. The ability of children to support their elderly parents should be realistically assessed.

Funk et al. (2013) conducted a research to exam associations among filial responsibility attitudes, self-rated health, and well-being within Caucasian Canadian, Chinese Canadian and Hong Kong Chinese sbu-samples. Their results showed that nether filial piety or self-related health were associated with carer well-being in their Hong Kong or Chinese Canadian sub-samples. However, lower filial expectancy was associated with better self-rated health in the Caucasian Canadian group. Funk et al. (2013) explained that a higher level of filial piety may have a more negative impact on carers of Caucasian Canadian. These researchers believed that in a Western cultural context, the feeling of responsibility for family members can be associated with feelings of guilt or inadequacy for some carers.

Another study was conducted by Chappell and Funk (2011) who found that Chinese Canadian’s care behaviors were more similar to homeland carers. It seems that western culture does not have clear and explicit norms of filial piety and where researchers have found that Chinese Canadian carers continue to provide extensive care to their parents.

Chinese Canadian Carer Decision-making Process

Placing a loved one in a nursing home is one of the most painful and difficult decisions to make for family carers (Chang, & Schneider 2010), especially in Chinese culture where filial piety is highly valued as a cultural norm. In Chinese societies, children traditionally have the duty to take care of their aging parents. Admitting parents to a long-term care home generally receives disapproval within Chinese society (Tew et al., 2011). Nursing home placement can be viewed either as an abandonment of old and sick parents, a traumatic experience, and/or an immense emotional burden on family carers (Zarit & Whitlatch, 1992). To understand the process and difficulties experienced by Chinese family carers when making a nursing home placement decision for their loved ones, Chen (2014) conducted a phenomenological study using crisis theory, social identity theory, and uncertainty management theory to conceptualize the decision making process around institutionalization among nursing home residents and their children in Shanghai, China. Twelve dyads of paired nursing home residents and their children were interviewed. According to Chen (2014), caregiving crises triggered intergenerational communication on caregiving decision making and eventually institutionalizing elderly parents. Children were in a superior position in the decision-making process, and elderly parents' declining health conditions prevented them from obtaining more decision-making autonomy. By communicating their concerns, children helped their parents to manage the uncertainties about institutionalization along the decision-making process (Chen, 2014).

Chang and Scheider (2010) conducted a similar study in Taiwan. The current researcher decided to discuss this study here based on her belief that the challenges with decision-making about nursing home placement as experienced by carers in Taiwan are the same as those experienced by carers in Canada. In Taiwan official circles, filial piety is often described in a matrix with other virtues. It is popularly understood and practiced by Taiwanese (Jordan, 2005). Thirty Chinese family carers were interviewed that resulted in the generation of a stage-based theory that described the carers' decision making process. The process began with initiating the idea of placement, assessing and weighting the placement decision followed, and ended with finalizing the decision. Most of the time, carers continued to evaluate the effects of placement that strongly influenced their adjustment after the placement. Sometimes carers changed their placement decision based on the well-being of their loved one. Of note, the current researcher did not locate a similar study conducted in Canada to explain the decision making process by Chinese Canadian family carers.

Drawing on Chang and Scheider's (2010) study to infer Chinese Canadian family carers' experiences, their findings described how Chinese family carers go through stages and what situations were involved in their decision-making. In the initiating the placement decision stage, these researchers focused on the situation that led to the initial idea of placement by carers. The main situation that lead to institutional care was related to the uncontrollable deterioration of the care recipient's health situation when carers were no longer able to manage and provide care at home. Many of the carers had chronic diseases themselves and when their health worsened, they were no longer able to provide appropriate care to the older care recipients at home. Some family carers experienced an unpleasant relationship with the older care recipient and other co-residing family members that contributed to the initiation of thinking about nursing home placement.

Also, insufficient family assistance resulted in a strong sense of feeling overwhelmed and a great burden for primary carers. As a result, many family carers sought professional assistance and began to consider institutionalizing the older care recipient.

When family carers began to engage in making a decision to institutionalize the older care recipient, they engaged in the second stage of decision-making: assessing and weighing the decision. According to Chang and Scheider (2010), family carers usually drew on different sources during the decision-making process that included speaking with their physicians, nurses, or friends, searching the internet, touring the nursing home, and/or reading the newspaper to obtain more information and opinions. Carers fully assessed the pros and cons of nursing home placement in terms of the quality of care, the level of assistance, their own health status, and their financial burden. Also, due to the collective nature of decision making, family carers also negotiated with other family members about the possibility of nursing home placement. Carers also sought the understanding of their parents (including the parent they were considering for nursing home placement). Many Chinese Canadian carers and care recipients will be unable to read or speak English that makes this stage more challenging. Elderly Chinese parents may not be able to choose their place of care based on their personal preferences. Older Chinese parents may have limited access to knowledge about long-term care services and insurance policies as well as limited resources to make such a decision. Thus, the balance of decision-making power may shift from elder to the younger generation. Adult children or key family members' preferences and their resources may have relatively greater power to influence the decision-making process (liu & Tinker, 2003).

Next in the decision-making process as described by Chang and Scheider (2010), is stage three that consists of three distinct patterns of finalizing the placement decision. The first pattern is called the consensual decision where the carer and other family members agree that nursing home placement is the best decision. The primary carer obtains support from other family members to reach an agreement. The second pattern depicts the partially consensual decision. With this type of decision, the primary carer experiences criticism due to family disagreement on the decision to place the care recipient in institutional care. The primary carer does not receive support from other family members. The primary carer decides to institutionalize their older care recipient due to a lack of support they received in the caregiving role. The third pattern is called the reluctant decision that depicts the primary family carer who is in disagreement with institutional placement but becomes convinced by other family members to do it anyway. These primary carers try to take care of the older care recipient at home because they believe that nursing home placement is an unfavourable, non-filial behavior.

The final stage was described by Chang and Scheider (2010) as evaluating the decision stage. Caregiving behavior did not end with the institutionalization. Instead, carers visited the nursing home frequently to ensure that their loved ones were receiving adequate care. Carers constantly examined the quality of care that the care recipients received in the nursing home. Some carers experienced regret and their decision about placement and desired bringing the care recipient back to the community. Some carers wanted to take their loved one back home when their physical condition improved. In other cases, carers felt disappointed or dissatisfied with institutional care. These carers most often complained about the lack of outdoor activities, insufficient hygiene routines, and falls by care recipients. If they could not take their loved one home, carers adjusted their expectations of institutional care. In some families, conflicts occurred during the decision-making process that continued after the decision was made to place the care recipient in institutional care. For some families, tense relationships existed for a long period of time. Some carers tried to make efforts to reconcile the familial relationships (Chang & Scheider, 2010).

In summary, existing research on the decision-making process of Chinese Canadian carers is limited. Related research conducted in social welfare and public health arenas provided some information on the decision-making process around institutionalization (Lai, 2004). Other large-scale studies have found predictors of elders' institutionalization, based on children's perspectives, such as declining ADLs and IADLs, diagnosis of dementia, bladder incontinence, falls and behavioral issues (Gaugler et al., 2003). The nuances of decision-making dynamics between generations remain understudied. Furthermore, extant studies have only investigated the perspectives of a single generation (i.e., only the elderly care recipient's or the child carer's perspective) (Chang et al., 2011; Won & Tae, 2012). However, this researcher believes that the perspectives of both generations influence the decision-making process about elder care. It is important for ongoing research to empirically study how different generations communicate with each other to reach consensus on institutionalization.

Filial Piety and Carer Decision-Making Process

As described earlier, culture plays an important role in shaping caregiving patterns. Filial piety has been at the core of the Chinese caregiving tradition, and it cannot be underestimated in the caregiving decision-making for Chinese elders because of its strong cultural and moral implications (Ma, 2006). According to Lai (2008), the traditional Chinese cultural value of filial piety is integral to familial structure governing over various aspects of Chinese societies. There is a strong expectation that elderly Chinese should be well taken care of by their children and families that includes living together and ensuring arrangements are made for appropriate supports.

In the context of Chinese Canadian caregiving, Chappell and Kusch (2007) examined the modern face of filial piety enactment among Chinese families. These researchers studied the roles of sons, daughters, and spouses in providing assistance with daily living. Over two thousand Chinese seniors living in seven cities across Canada participated in the study. The findings revealed that, among diasporic Chinese, patterns found in other Chinese societies were evident in their tendency to live with children even when the spouse is still living. Chappell (2013) also did a comparison study earlier between Shanghai Chinese Canadian and non-Chinese Canadian seniors living in British Columbia. Similar results were found where Chappell (2013) found a greater involvement in caregiving by Chinese children than is commonly seen in the wider Canadian caregiver population. Also, the traditional caregiving arrangement in China contrasts with the primacy of spousal caregiving in the West that is followed by the primacy of daughters when a spouse is not available. Chappell (2013) reported that only nine percent of older Canadian adults were living with their adult children or other relatives. Lai (2008) stated that for Chinese family carers in a Western society, their decision to put loved ones in a long-term care facility is challenging. Their concerns are due to the limited capacity of facilities to support the cultural and language needs of older Chinese care recipients.

Lai (2004) identified filial piety, caregiving burden, care recipient’s level of care needed, and health conditions as common predictors of elderly Chinese Canadians’ intention of using long-term care facilities. Lai’s (2004) findings showed that 40.9% of Chinese-Canadian family carers would consider using long-term care facilities if the health condition of their family members deteriorated; 59.1% indicated that they would not consider this option. In addition, among all the older Chinese participants in this study, an overwhelming majority (i.e., 80.3%) indicated that if they were in need of living in a long-term care facility, they would prefer to live in a facility specially designed for Chinese residents with mostly Chinese staff. Lai (2004) described that traditional cultural values and norms continued to evolve as a result of carers’ exposure to and interaction with the dominant sociocultural environment. Therefore, this researcher aims to explore the common myth that because the Chinese culture has placed such a strong value on providing care to aging parents, family carers would have no need for formal care and support services. A significant portion of aging Chinese Canadians reported that they would consider applying for long-term care, which reflects the reality that faces many aging Chinese in Canada. Many aging Chinese Canadians realize that they may require care that their children may not be able to provide (Lai, 2004).

Lai (2008) also described that Chinese family carers would use available services for the sake of better care for the care recipients. In China, due to changing social, demographic, and economic structures over the past two decades, care of older adults is currently shifting from family-centered care inside the home to community based nursing home care outside of the home (Lai, 2008). Contributions towards the evolution of elder care in China include increased life expectancy in older adults and cognitive impairment that require a complex skill set to the extent that carers are not able to provide necessary, safe, and quality care at home.

Feng et al. (2011) demonstrated that in China, less than 10% of Chinese elders seek formal long-term care. However, this rate has been growing in recent years. Regardless, most Chinese elders still prefer family caregiving to formal long-term care due to the ingrained filial piety tradition (Feng et al., 2011). Filial piety is a unique contextual factor that cannot be ignored in the context of decision-making processes by Canadian Chinese caregivers. Filial piety has a fundamental impact on families' decisions to institutionalize elderly Asian parents. This impact is both lingering and compelling, such that even the second and third generations of Korean immigrants feel ashamed about institutionalizing elderly parents in the United States (Kim et al., 2006). The decision to institutionalize in the United States often occurs when family carers have not yet depleted their caregiving resources (e.g., finances, the carer's or care recipient's s health condition, or available supports). However, a traditional Chinese family may wait until carers burden exceeds one's resources and a caregiving crisis occurs before seeking assistance and placement (Chang & Schneider, 2010). Traditional Chinese filial piety can have a strong impact on adult children's decision-making to utilize a nursing home for the care of older adult family members.

Filial Piety and Caregiver Burden

Filial piety is an important cultural value that affects not only decision-making about caregiving arrangements, but also caregiving experiences that can lead to carer burden. Lai (2009) conducted a quantitative telephone survey to examine the effects of filial piety on the appraisal of carer burden in a random sample of Chinese Canadian family carers of elderly care recipients. The findings indicated that filial piety affected Chinese Canadian family carers' experiences. Filial piety was significant in predicting how carers perceived the values, gains, and costs of providing care. The more strongly carers identified with filial piety, the greater the likelihood they would perceive caregiving as being positive, beneficial, and less costly. Therefore, positive carer appraisals resulted in lower carer burden. This finding is consistent with previous research results (Cheung et al., 1994). According to Lai (2007) being an immigrant, having a Western or non-Western religion as compared to having no religion, and having a lower level of filial piety were predictors of a higher level of carer burden. In Lai's (2007) study, filial piety served as a protective factor against carer burden experienced by Chinese Canadian carers.

However, controversies were found in the literature on the protective value of filial piety and carer burden. Some researchers reported that filial piety could potentially increase carer stress. For example, a recent Chinese study by Kim and Kang (2015) revealed findings that contradicted Lai's (2007) study findings. Kim and Kang (2015) collected survey data from 295 family caregivers in China from January to February 2014. These researchers investigated how filial piety and intimacy were experienced in the context of family carer stress. In particular, these researchers examined the effect of filial piety and intimacy on carer stress according to the status of living with parents. Based on the results of this study, filial piety was interpreted as a type of social pressure to provide caregiving rather than an individual’s choice to engage in caregiving based on one’s emotional relationship with one’s parents. Greater filial piety was correlated with greater caregiving stress. In other words, the carer may have realized that he or she cannot reduce one’s burden due to filial duty that contributed toward carer stress. According to Kim and Kang (2015), high filial piety implies an emphasis on cultural values may increase carer stress. Further, filial piety speaks to an affection for parents and self-sacrifice and devotion which may be viewed as unsuitable or unrealistic concepts for adult married children in modern China. Funk et al. (2011) further explained that a high sense of filial piety may have more negative impacts for carers because feelings of responsibility for family members can be associated with feelings of guilt or inadequacy for some carers, as well as restrictions on personal and parental autonomy. Based on extant empirical findings, inconsistencies exist in the relationship between filial piety and carer burden. In this researcher’s opinion, inconsistent study findings exist due to ‘when’ the study was conducted and ‘who’ was interviewed. A large number of studies were conducted more than 10 years ago with a localized population, such as Chinese Canadians living in Calgary. Also a large number of studies involved telephone interviews to obtain sensitive information thus making results less reliable. Therefore, this researcher believes that more sensitive methods, such as qualitative approaches, are needed to further explore this issue.

Finance

Statistics Canada (2013) reported that among regular family carers, 7% reported financial difficulties as a result of their caregiving responsibilities with their parents. Many family carers needed to incur out-of-pocket expenses. In addition to financial difficulties, many carers needed to combine caregiving duties with professional obligations that resulted in the loss of hours worked and a reduction in productivity that contributed toward decreased income or even job loss. Statistics Canada (2013) also reported that approximately 10% of family carers caring for their father or mother had not worked in the previous 12 months. Chappell (2003) conducted a cross-cultural study and found that Chinese seniors, whether living in Shanghai or in Canada, maintained a practice of financial assistance from children. According to Government of Canada (2018), if parents were sponsored by their children to immigrate to Canada, they are not eligible to apply for social assistance for 20 years. Given the fact that a lot of Chinese seniors have not lived in Canada for 20 years, they are financially dependent to their children. Chang and Schneider (2010) stated that when carers make medical decisions for their parents, they have to consider their own situation in terms of values, health, and financial status. In a sense, they are not only making the decision for their loved ones, but for themselves and their families. Tew, et al’s (2011) study revealed that the key to delaying institutionalization lies in fulfilling the fundamental prerequisite of having a carer at home. Therefore, empowering carers with tangible assistance in the form of financial aid can be useful. These authors believed that financial assistance can take the form of a carer allowance that provides family members with finances to stay at home to care for the elderly parents (Tew et al., 2011).

Family Caregiving Crisis and Carer Availability

It is not uncommon for a crisis in family caregiving to arise when the demands for care exceed what support the carer is able to provide to care recipients. In addition to their ongoing responsibilities, carers may be confronted with emerging care recipient needs that place additional demands on their time and energy which can be viewed as a “crisis” (Sims-Gould, Martin-Matthews, & Gignac, 2008). Such crises can be caused by the care recipient’s deteriorating or health condition that can be temporary or occur more gradually. The changes evoke emotional and instrumental caregiving tensions that need to be addressed. Sims-Gould, Martin-Matthews, and Gignac (2008) emphasized that the range of crises can be health-related, social, emotional, financial, and even idiosyncratic to a family. Crises may motivate different generations of the family unit to reconsider the carer role and initiate the decision-making process around institutionalization. When this happens, carer availability makes a huge difference in terms of the decision. Tew et al. (2011) argued that carers who do not hold a job are less likely to choose institutionalization for the elder parents. The key to delaying institutionalization lies in fulfilling the fundamental prerequisite of having a carer at home**.** After the basic requirement of a carer has been met, Tew et al (2011) also suggested several interventions to bolster the availability of family carers and delay institutionalization of the care recipient. They suggested interventions that are directed at lowering carer stress and empowering carers with better coping skills. Early utilization of home care service can help delay institutionalization. They also suggested that empowering carers with tangible assistance in the form of financial aid can be useful.

Availability of Nursing Home and Access to Health Care Service

According to Manitoba Health, Seniors and Active Living Information Management and Analytics (2018), in 2016/2017, there were 125 Personal Care Homes (PCHs) in Manitoba. Almost three percent (i.e., 2.9%) of the population aged 75 years and older were admitted to a PCH from 2015/2016 to 2016/2017. The median wait time for placement into a PCH was approximately eight weeks, and the median length of time a resident spent in PCH was 1.9 years. Length of stay is associated with level of care on admission, as sicker patents stay less time in a PCH than healthier patients do. Manitoba Health, Seniors and Active Living Information Management and Analytics (2018) also released data for home care use. In in 2016/2017, there were 16,641 Manitoba residents admitted to home care, and 16,066 were discharged. No data specifically indicated minority group use of home care services or PCHs. However, according to Lai (2004), immigrants are vulnerable to stress and stress-related mental health problems. Language barriers, lack of knowledge and understanding of the existing service system, acculturation stress, cultural shock, and other adjustment issues continue to exist. Due to cultural differences and service barriers, this researcher speculated that many elderly Chinese Canadians may not have the same access to resources (i.e., medical services or information about PCHs) as local, English-speaking Canadians.

Nurse Role in the Decision-Making Process

Meeting the General Needs of Carers

Carers provide complex personal care and practical and emotional support, and may be needed at any time of day or night. They have multiple roles for which they have rarely been trained, and consequently may feel ill-prepared and lack confidence in their ability to care, which causes anxiety and reduces their ability to ask for help (Farquhar, 2017). Carers are hidden patients themselves. However, the lack of explicit attention by health care professionals to carer needs is a serious gap in health care (Reinhard et al., 2008). Most patients that nurses encounter have families that are providing some level of care and support to the patient. To nurses, family carers are sometimes referred to as “second patient” who need teaching and care as well (Reinhard et al., 2008). Family carers often need to learn how to provide competent, safe, and optimal care for the care recipient. Kurtz, Given, Given and Kurtz (1994) indicated that as the stage of illness progresses, carers experience serious adverse physical and mental health consequences. Nurses need to proactively approach family carers to provide them support across the caregiving continuum.

Scherbring (2001) conducted a study to learn more about family carer levels of caregiver burden and perceptions of preparedness for the caregiving role at hospital discharge. This researcher’s results showed that increased levels of preparation were associated with decreased caregiver burden and that this relationship did not change over time. Therefore, it is very important for the health care team to provide appropriate interventions to ensure that carers are prepared for their responsibilities. Family carers reported that they were confident about their care and were able to look back upon the caregiving experience without regret when they felt supported in their role (Edwards et al., 2012).

Farquhar (2017) suggested to create a new role for nurses called the “carer support nurse role" in his article. According to Farquhar (2017), a key aspect of the carer support nurse role would be educating other health professionals and raising their awareness of carer recipients' and carers' needs. This role would apply the principles of person-centred care by supporting carers according to their needs, circumstances, and preferences. Nurses in this role would also show compassion that enables them to develop their strengths through recognition education and ensure their care is coordinated through interprofessional liaison (Farquhar, 2017).

Reinhard et al. (2008) described detailed interventions designed to help carers become a more competent and confident provider. Major intervention components need to include: (1) strengthening caregiver competence by improving carer's control over the situation; (2) developing task-specific and problem-solving skills; (3) offering psycho-educational supports such as training carers on how to manage behavioural disturbances; (4) guiding carers on how to navigate the service delivery system to obtain information, services, and equipment; (5) recognizing and respecting family carers' caregiving efforts as well as assessing their needs, providing concrete instruction on the specific care they are giving, and referring carers to resources for ongoing helpand, (6) assessing carers' needs and capacities to provide care. In this researcher's opinion, these are nursing interventions and supports that should be skillfully extended to all family carers regardless of cultural background.

Supporting Decision-Making Needs of Carers

One role of the nurse is to assist carers with decision-making about elder care. To comprehend this role, Dalton (2003) extended the theory of collaborative decision-making in nursing practice by including family carers into the decision-making process to become a triadic theory. According to Dalton (2003), the nurse interacts with and assists not only patients, but family carers as well. Dalton's (2003) data revealed variety in the nature of the patient-carer-nurse relationship (or triadic relationship), a multitude of decisions considered, and a range of collaborative and coalition-forming interactions. Dalton (2003) also found that the way decisions were made depended on the collaboration of triadic members. The patient, carer, and nurse role in decision making varied according to the context of participant and situation. Dalton (2005) further explored the nurse's involvement in decision making. This researcher's study extended our knowledge of decision-making by focusing on the well-documented importance of carers and about coalition-formation during patient-caregiver-nurse interactions. Dalton's (2005) findings also enhanced understanding of these triadic interactions and how to facilitate communication in this situation.

In summary, nurses play an important role in assisting family carers in a range of different ways. However, most studies on decision-making about elder care by carers of different cultural backgrounds have not attended to the cultural competence of nurses in supporting carer decision-making. Canada's multicultural society that requires nurses who are skilled in cultural competence to guide family carers in their decision-making about elder care.

Collaborative Decision Making and Cultural Competence

Louw (2016) defined cultural competence as a dynamic, complex and continually evolving process of skill development by health care professionals. Health care professionals who are skilled in cultural competence are able to respond appropriately to their patients' unique combination of cultural variables and ensure efficacy in working within the cultural context of their patients. Important factors for the nurse to consider in the provision of culturally competent care include careful consideration of the carer's and care recipient's age, beliefs, customs, ethnicity, language, gender and gender identity, sexual orientation, religion, etc. Cultural competency in nursing practice is the cornerstone of providing superior care for people of all cultures (Louw, 2006). Cultural competence involves a continuous process where nurses work effectively and efficiently within a patient's culturally dictated world. Stanhope and Lancaster (2000) described that culturally competent nursing care is guided by four principles: (1) care is designed for the specific patient; (2) care is based on the uniqueness of the person's culture and includes cultural norms and values; (3) care includes self-empowerment strategies to facilitate patient's decision-making in health behavior; and, (4) care is provided with sensitivity based on the cultural uniqueness of patients. The culturally competent nurse understands that each person is unique and to be respected as a cultural being in the decision-making process (Linda, 2013).

In recent decades, there has been a growing recognition that physician-directed healthcare does not always translate into the best outcomes for most patients. As well, the importance of the patient's role in decision-making has been recognized (Hawley & Morris, 2017). There have been repeated calls for health interventions to be more inclusive of patients in decision-making. More specific to culturally appropriate decision-making, Hawley and Morris (2017) summarized some suggestions for consideration in advancing the provision of more culturally appropriate shared decision-making processes. These authors mentioned the key role of family and community. According to Hawley and Morris (2017), cancer patients who come from culturally- or ethnically-diverse backgrounds tended to involve family and friends in treatment decision-making more frequently than white patients. Engaging patients from diverse backgrounds in shared decision-making will likely mean involving and incorporating their family carers.

This researcher attempted to locate literature on the nursing role and cultural competence in supporting the decision-making processes of family carers; the information is limited. Therefore, this researcher believed more study is required on support for family carers of older adult Chinese Canadians in their decision-making on long-term care and home care services.

Summary

This chapter has summarized relevant literature sources related to Chinese Canadian carers, their decision making processes, and the nurse’s role in the decision-making processes of carers about the long-term care of their older relatives. Even though there is a large number of studies investigating predictors of seniors’ institutionalization, service use and caregiving experiences in Western health-related literatures, little research has been done on Chinese Canadian family carers. A knowledge gap also emerged as to the nurse’s role in supporting the carer-care recipient decision-making process in the context of competent cultural care. This study fills this knowledge gap by identifying Chinese Canadian family carers’ unique caregiving and decision-making processes, and exploring the nurse’s role in supporting Chinese Canadian family carers.

CHAPTER THREE

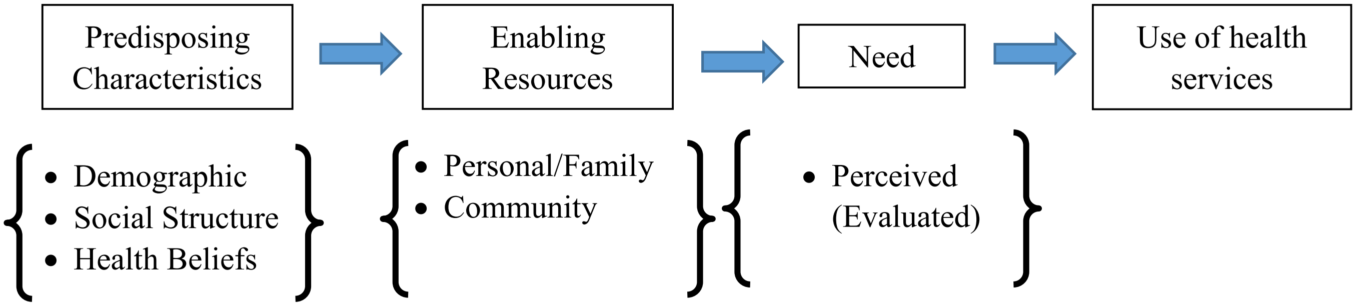
CONCEPTUAL FRAMEWORK

This study was guided by Andersen's behavioral model of Health Services Use developed by Anderson (1968). The purpose of this chapter is to review Andersen's (1968) behavioral model that this researcher employed to examine predictors of service use and intention of putting parents into a nursing home. The Andersen's Behavioral Model is mostly used for investigating health services utilization which was deemed appropriate for this thesis topic.

Andersen's Behavioral Model of Health Services Use

The initial Behavior Model was developed by Anderson in the 1960's to assist in the understanding why a family uses health services (Anderson, 1968). The second Model was re-developed in the 1970's by Anderson and Newman (1973) and is known as the Anderson-Newman Model. Anderson and Newman (1973) described that the utilization of health services is a type of individual behavior. They suggested that how people intend to use health services is affected by three groups of variables. The first group of variables is called Predisposing factors and are socio-cultural and demographic characteristics of individuals that exist prior to their illness (e.g., age, gender, race, education, and marital status). The second group of variables is called Enabling factors that capture logistical aspects of obtaining care. Enabling factors refer to the availability and accessibility of a variety of community and family resources (e.g., income, accessibility, or knowledge about services). The third group of factors is referred to as Need factors or the individual's functional capacity and general state of health. People who have more health and psychosocial problems are more likely to have a higher level of use of health care and social services (Figure 1). Although this Model was originally applied in the context of medical practitioner consultations in hospital settings, it has been extended to other contexts of health care utilization such as the use of professional home care services by the elderly (Kempen & Suurmeijer, 1991).

Figure 1. The initial Behavioral Model in 1960s (modified from Anderson, 1995)

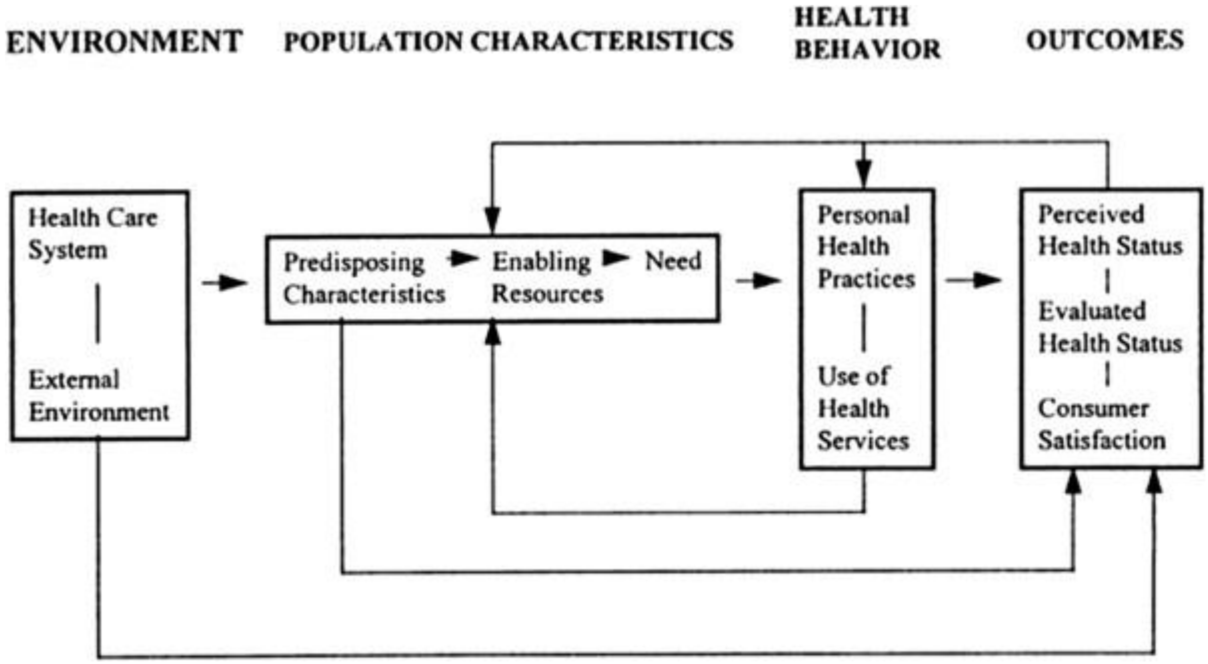


Note. From the behavioral model and access to medical care: Does it matter? By R. M. Anderson, 1995, *Journal of Health and Social Behavior, 36* (March), 1-10 (Used with permission)

In recent years, the Anderson-Newman (1973) paradigm has been applied in predicting the use of different types of social and health services. Li (2006) employed this Model to analyze rural older adults' access to assistive devices, transportation services, and in-home and community based services plus identify older rural adults' specific access barriers to health and social services. Bradley et al. (2002) expanded the Andersen-Newman (1973) Model by enhancing two aspects of the Model. First, they argued that "beliefs" as described by Andersen and Newman (1973) may not adequately capture the breadth of psychosocial factors germane to race or ethnicity-related variations in long-term care use. In other words, individuals may have specific cultural knowledge and attitudes toward tasks like cooking, shopping, dressing, bathing, and toileting. Therefore, Bradley et al. (2002) believed that these factors may be more important as predictors of long-term versus acute care service utilization. Second, Bradley et al. (2002) explained how the Andersen-Newman Model (1973) combines race or ethnicity with other demographic characteristics in a variety of inter-relations. There is the potential for an omission of interrelationships that could oversimplify the role of race or ethnicity in service use. Therefore, in their research, Bradley et al. (2002) specified the nature of psychosocial factors and enhanced the role of those factors in the context of long-term care decisions. They found that psychosocial variables may mediate the effect of race or ethnicity on long-term care service use. For example, they found that "African-Americans, in comparison to white elders perceived poorer access to needed information, reported stronger norms of family caregiving, and had more concerns about potential loss of privacy and self-determination in long-term care settings" (Bradleyet al., 2002, p. 1238). All of these studies demonstrated that the Predisposing, Enabling, and Need factors were significant predictors of service use, and there is much variability in the contribution of the different factors (Cohen-Mansfield et al., 2013).

In 1995, Andersen revised the Model that has become one of the most widely acknowledged Models and is known as The Behavioral Model of Health Service Use. The initial Model focused on the use of health services by the 'family' as the unit analysis. However, Andersen (1995) revised the Model to focus on the analysis of the 'individual'. The current Model has a feedback loop to illustrate that health outcomes may affect aspects such as health beliefs and need. The Model also has genetic susceptibility as a predisposing determinant and quality of life is an outcome. In being guided by the Model's postulated relationships, we can determine the directionality of variable effects on the outcomes following a change in any of the environmental factors or population (i.e, the individual's) characteristics as depicted in Figure 2. For the purpose of this study, "population characteristics" will refer to "individual characteristics".

Figure 2. Andersen's The Behavioral Model of Health Service Use (1995)



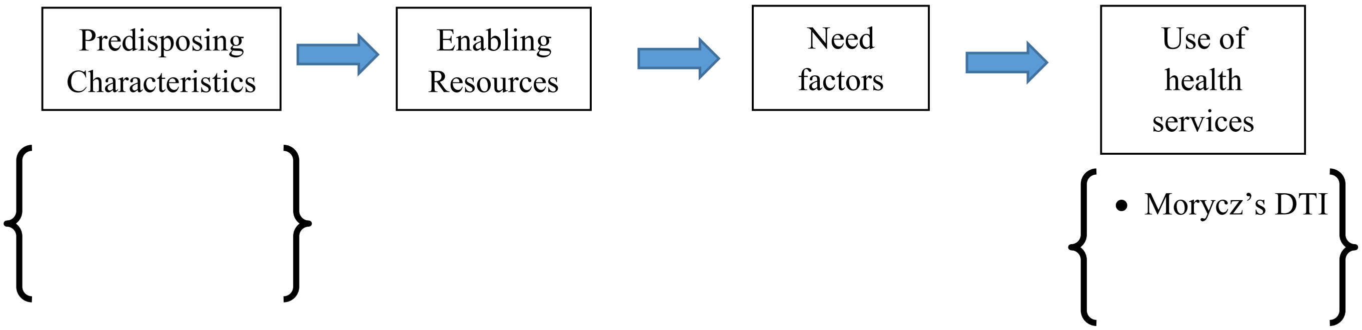
Note. From Revisiting the behavioral model and access to medical care: Does it matter? By R. M. Anderson, 1995, Journal of Health and Social Behavior, 36 (March), 1-10 Used with permission

Use as a Guiding Framework in the Current Study

In this study, the Andersen's Behavioral Model (Andersen,1995) was used to examine the intent of Chinese Canadian family carers to use health care services and long-term care for elderly relatives. As guided by the Model, the Predisposing factors in this study included social structure factors (i.e., education, occupation, ethnicity, social networks, and culture), health beliefs (i.e., filial piety attitudes, values, and knowledge that carers have towards the health care system), and demographic information (i.e., age, gender, and years of immigration to Canada). Enabling factors were analyzed from personal, family. and community perspectives. From the personal and family perspective, this researcher examined the family carer's ability and willingness to access health services, income level, and their regular source of care. From the community perspective, this researcher examined the availability of nursing home services and wait times.

As indicated in Figure 3, this researcher developed demographic survey questions to capture carer and care recipient demographic information as potential independent variables. A 10-Item Contemporary Filial Piety Scale (CFPS-10) was used to capture the independent variable of carer participants' filial piety level. The Care Caregiving Burden Inventory (CBI) was use to assess the independent variable of carer burden level that is a need factor. The dependent variable of carer intention to use long-term care was captured by Morycz's Desire-to-Institutionalize Scale (Morycz's DTI scale).

Figure 3. The Use of Andersen's Behavioral Model in this study.



- Demographic
- CFPS-10

- Personal/Family
- Community

- CBI

The Need factors included the number of health conditions of the care recipient and the level of carer burden. Filial piety was also included as a predisposing factor of carers because the Chinese culture places a very strong emphasis on providing care to elderly family members.

In summary, this researcher employed Andersen’s Behavioral Model of Health Services Use (Andersen, 1995) for her project. Although this Model has not been used with other Chinese Canadian populations to study their decision-making about elder care, it guided this researcher’s analyses of factors impacting family carers’ intentions to use long-term care and other health services. This Model provided a solid foundation for this researcher to examine relationships among variables in this study.

CHAPTER FOUR

METHODOLOGY

This chapter describes the methodology selected to address the research question. The methodology section of this chapter introduces the research design and rationale, sample, research setting, instruments as well as data collection methods and planned data analysis. The relevant ethical issues in relation to this research is also discussed in this chapter.

Purpose

The main aim of this study was to examine Chinese Canadian family carers' experiences with filial piety and decision-making about long-term care and home care services for their aging parents. Guided by Anderson's Behavioral Model (Anderson, 1995), quantitative methods allowed the researcher to capture and examine the relationships between Predisposing factors, Enabling factors, and Need factors and family carers' intention to use long-term care facilities and home care services for their parent.

Research Question

The researcher answered the following research question:

What is the association of Predisposing characteristics (e.g., demographic characteristics, filial piety), Enabling resources (e.g., access to health services) and Need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making process about long-term care?

Research Design

A quantitative design was employed to explore and identify factors that influence family carers' intention to use health services and long term care for their parent.

Study Variables

In the current study, the independent variables were carer and care recipient's demographic information, Carer's filial piety scale, and care burden level. The dependent variable or main outcome variable of interest to this research was carer intention to use long-term care facility for their parents.

Methodology and Rationale

Based on this researcher's review of the literature, the majority of studies on Chinese Canadian family carers in the last two decades employed quantitative methods (e.g., Lai, 2004). Telephone surveys were mostly used to collect information in Dr Lai's studies (e.g., Lai, 2004, 2007, 2008). Sellers (1999) described that quantitative research focuses on what proportion of targets think a certain way and qualitative methods capture how people think. Given the complexity of this topic, this researcher believed that a quantitative or qualitative research method alone would not sufficiently answer the research question. Therefore, this researcher decided to employ quantitative tools that were supplemented by open-ended questionnaire items for participants to describe any barriers or facilitating factors that impacted their decision-making about long-term care and home care services use for their elderly loved one.

Quantitative Inquiry

Quantitative research methods deal with numbers and concepts that are measurable in a systematic way. Quantitative methods are used to answer questions about relationships between measurable variables with the intention of explaining, predicting, and/or controlling a phenomenon (Plonsky & Gass, 2011). The use of reliable questionnaires was employed in the current study by this researcher to capture and examine the main relationship of interest between filial piety and Chinese Canadian family carers' decision-making processes about long-term care and/or home support services. This researcher also employed sound psychometric tools to examine the association of Predisposing characteristics, Enabling resources, and Need factors with the carers' decision-making process about long-term care and use of home care services.

Setting

Burns and Grove (2003) stated that quantitative research can be conducted in three different types of settings: i.e., in a natural setting, a partially controlled setting, or a highly controlled setting. Among those, a natural setting offers no control in a real life setting, and it is frequently used for descriptive and correlational studies (Burns & Grove, 2003). For the current study, Chinese Canadian family carers were recruited as participants from natural community settings in the City of Winnipeg, Manitoba.

Population and sample

Polit and Beck (2012) described convenience sampling as using the most easily accessible people as participants, and it can be used when researchers are seeking people with certain characteristics. The target population for this study was Chinese Canadian family carers who were living in Winnipeg. A convenience sample of family carers was recruited based on eligibility criteria described below. Individuals met the criteria as a family carer for this study if they were:

1. Male or female
2. Aged 18 years or older
3. Able to speak and read English or Mandarin
4. An ethnic Chinese individual residing in Canada
5, The primary carer of an elderly family member
6. Willing to participate and able to provide consent (Appendix A)

Sample Recruitment Procedure

Participants for this study were recruited from a population of Chinese Canadians living in Winnipeg, Manitoba, Canada. The following websites were used to post advertisements about this study: https://www.chinesewinnipeg.com, http://www.58winnipeg.com, and http://yishizhuxing.ca. A Chinese supermarket Wenkai Supermarket (located on 2247 Pembina Hwy) in Winnipeg was also used to post the information about this research.

A letter of invitation to participate in this study (Appendix B) was posted online and in the Chinese supermarket listed above. This invitation letter included information about the researcher (i.e., her student status and affiliation with the University) as well as an overview of the study purpose. Contact information for the researcher was included in the invitation letter.

Potential participants were provided the opportunity to contact the researcher for further information about the study.

A web link was provided in the advertisement for Chinese family carers who were interested in taking part in the study to complete the on-line informed consent form (Appendix A) and then the on-line questionnaire. Family carers were provided the option to complete the consent form and questionnaires in person or by phone. Prior to completing the study questionnaires, an informed consent form was available on-line. The informed consent explained to the participant that he or she is free to leave the study at any time during the on-line survey or to refuse to answer a question. The questionnaires were translated in Chinese by the researcher. Participants would select using the Chinese or English version to provide their on-line responses. Of note, this researcher was fluent in speaking and reading the Chinese language. The researcher was able to communicate with participants in Chinese and perform the interviews in Chinese as needed. For two of the open-ended questions, the researcher translated all written Chinese into English responses. Participants were informed that confidentiality would be maintained and that none of their interviews will be shared with anyone other than the researcher (see informed consent in Appendix A).

Data Collection

Data collection for this study occurred over one-month period from September, 2019 to Octomber, 2019. Online questionnaires were entered into an internet program called Qualtrics (Qualtrics, Provo, UT) with the assistance of Mr James Plohman, Research Coordinator, Manitoba Center for Nursing and Health Research.

In order to describe the characteristics of the sample and collect information about family carers' experiences with decision-making about the use of health services and long-term care facilities, the following research instruments were utilized. As guided by Andersen's (1995) Behavioral Model of Health Service Use, the researcher captured carers' responses to access to health services and attitudes toward institutionalization (i.e., Enabling resources), and the care recipient's functional capacity and level of caregiving burden (i.e, Need factors).

Demographic Data Collection Form. A demographic form (Appendix C) was developed by this researcher and included questions about the family carers' age, marital status, language, occupation, years living in Canada, health conditions, financial status, and length of time in the caregiving role. Data from the demographic questionnaire was used to describe the sample and examine the research question related to Predisposing characteristics, Enabling resources, and Need factors.

Contemporary Filial Piety Scale (CFPS-10). Lum et al. (2016) argued that the experience and practice of filial piety have evolved in modern Chinese societies, and existing measures fail to capture these important changes. Based on a conceptual analysis on current literature, 42 items were initially compiled to form a Contemporary Filial Piety Scale (CFPS), and over 1,000 individuals in Hong Kong were surveyed in the included studies. As a result, Lum et al. (2016) determined that the Contemporary Filial Piety Scale (CFPS-10) tool was most appropriate for use in capturing filial piety in society today. The CFPS-10 is a 10-item, two-factor tool that is data-driven, simple, and efficient to use. The CFPS-10 is a tool that has strong psychometric properties for assessing contemporary filial piety. The Cronbach's alpha for the CFPS-10 was 0.88, and the instrument has been tested in a representative Chinese sample in Hong Kong (Lum et al., 2016). In the current study, the CFPS-10 was used to capture the practice of filial piety among Chinese Canadian family carer participants. A five-point Likert scale was used, with "1" indicating "not important" to "5" indicating "very important" (see Appendix D). Here are some examples of the questionnaire response items on the CFPS-10": "Arrange care for parents when they can no longer care for themselves", "Provide financial subsistence to parents when they can no longer financially support themselves", and "Be thankful to parents' nurturing".

Care Giver Burden Inventory (CBI). Carer burden is broadly defined as encompassing the physical, psychological, emotional, social and financial stresses that individuals experience due to providing care (Bastawrous, 2012). According to Novak et al. (1989), a number of unidimensional burden scales have been developed with a focus of learning carer's feelings and experiences. They used the Care Giver Burden Inventory or CBI in their research where they interviewed 107 carers. Their experience with the tool helped them to avoid some of the methodological problems associated with earlier work (i.e., tools that had a high ratio of items to subjects). Further, Novak et al. (1989) argued that the CBI offers a multidimensional measure of caregiver burden. Valer et al. (2015) conducted study in Brasil using the CBI tool. Their results revealed a Cronbach's alpha value for the Inventory was 0.94, and the Pearson correlation coefficient for the relationship between the scores obtained on the CBI and the Burden Interview was 0.81. They concluded that the CBI instrument presented adequate reliability and the suitability of its terms and factors (Valer et al., 2015). Chou et al (2002) examined the psychometric properties of the Chinese version of the CBI for its utility in clinical and research practice in China. A paired t-test and intra-class correlation indicated that the Chinese version of the CBI was a good reflection of the English version and demonstrated item equivalence. These results revealed adequate internal consistency reliability estimates and appropriate content and concurrent validity. These results support the use of the Chinese version of CBI as a research instrument in measuring the carer burden in the Chinese population (Chou et al., 2002). Therefore, the researcher adopted the CBI in this study to capture Chinese Canadian family carers' felt burden (Appendix F).

Morycz's Desire-to-Institutionalize Scale (DTI). Again, as described above, when it comes to the decision of institutionalization, Need factors such as carer burden play an important role. Many professionals believe that institutionalization can reduce family carer's burden from the caregiving role. DTI is the dependent variable in this study. Morycz's Desire-to-Institutionalize Scale was developed by Morycz in 1985. Mccaskill et al. (2011) slightly modified the initial version of Morycz's DTI scale in order to incorporate the term 'assisted living' which was not standard vernacular at the time that Morycz's DTI scale was published. This researcher will use the modified version of Morycz's DTI scale (Appendix E) in this study to assess Chinese Canadian family carers' desire to institutionalize their elderly parents. The scale contains six items that assess a carer's desire to institutionalize a care recipient. The scale consists of 'yes' and 'no' dichotomous responses. The scale asks the carer about his or her plans, thoughts, and discussions with others about institutionalizing the care recipient. The total score of the scale was calculated by summing the responses across all questions, unweighted. Scores ranged from “0” to “6” with higher scores indicating a greater desire to institutionalize the care recipient (Mccaskill et, al, 2011). The reliability coefficient for this scale was 0.74. The scores provide some indication of the stress involved in the family caretaking process. The objective stress scale had a strong reliability coefficient of 0.83 (Morycz, 1985). Exploratory factor analysis (EFA) and reliability analyses were performed by Mccaskill, et.al. (2011). The EFA revealed a one factor structure that was equivalent across all racial groups. The scale demonstrated moderate reliability with KR-20 alpha of 0.69 for Whites, 0.74 for African Americans, and 0.77 for Hispanics. This finding suggested that Morycz’s DTI scale is a consistently reliable measure for assessing the desire to institutionalize across cultural groups.

Below are two open-ended supplementary questions (Appendix G) that were posed to participants about any barriers and facilitating factors they experienced during their decision-making about long-term care and use of home care services for their loved one. These open-ended questions were added at the end of the on-line survey. These open-ended questions were developed based on the work of Chen (2014), Caldwell, Low, and Brodaty (2014), and Chang and Schneider (2010).

1. What are some barriers that do not help you to make a decision about long-term care and use of home care services for your loved one?

2. What are some facilitators that help you make a decision about long-term care and use of home care services for your loved one?

Protection of Human Subjects

Prior to the commencement of data collection, written ethical approval from the University of Manitoba Education/Nursing Research Ethics Board was obtained. The Protocol number is: Protocol #E2019:057 (HS23043).

Participation in the current study was strictly voluntary and participants were told that they are able to withdraw from the study at any time as described in the informed consent form. Prior to data collection, the informed consent form was provided to participants on-line. The process of obtaining written informed consent provided an important opportunity for the researcher to communicate details about the study, as well as potential risks and benefits associated with participating in the study (Casarett & Karlawish, 2000). As an experienced nurse, the researcher was well aware about the vulnerability of the population and she endeavored to provide sufficient detail about the study and the role of participants in the on-line informed consent form. If requested by the participants or identified as a need by this researcher, participants were provided with resources for social support such as the Seniors Information line, the Manitoba Seniors' Guide, and/or contact information for Health Links.

All study data were collected through an online survey link common to all survey participants. So the data collected from many survey participants were anonymous. Also, all of the data collected would be accessed only by this researcher, Dr. Michelle Lobchuk (thesis advisor), and Dr. Rashida Rabbani (statistician at the Manitoba Centre for Nursing and Health Research). Participants were also informed that their data files were be kept on the password-protected server at the University of Manitoba. All study documents will be kept for seven years at this researcher's residence in a locked filing cabinet or on a pass-word protected computer for seven years and then destroyed by shredding or deleting them in June 2026.

Data Analysis

For analyses of quantitative data, this researcher reviewed the preliminary data analysis plan with Dr. Rashida Rabbani, Biostatistician, Manitoba Centre for Nursing and Health Research. Descriptive data analysis included descriptive statistics (i.e, means, frequencies, and range) of sample characteristics and study variables as captured on study questionnaires (R. Rabbani, personal communication, Februrary 7, 2019).

To answer the research question, "What is the association of Predisposing characteristics (e.g., demographic characteristics, filial piety), Enabling resources (e.g., access to health services) and Need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making process about long-term care?", data were examined to ensure they met the assumptions for parametric tests. If assumptions were not met, under the guidance of Dr. Rabbani, this researcher employed non-parametric statistical analysis to answer the research question (Corder & Foreman, 2014).

Upon the advice of the biostatistician, linear regression was employed to address the research question. According to Munro (2005), linear regression makes use of the correlation between variables and the notion of a straight line to develop a prediction equation. Regression allowed this researcher to predict outcomes and to explain the interrelationships among variables. Guided by Andersen's (1995) Behavioral Model of Health Service Use, this researcher examined the relationship among the following factors with the carer's intention to use health services: Predisposing factors (i.e., filial piety, demographic characteristics), Enabling factors (i.e., carer's intention to use services or long-term care), and Need factors (i.e., level of caregiver burden). The significance level for statistical analyses was set at $p \leq 0.05$. SPSS was employed to conduct rigorous analysis of the data.

Content Analyses of Supplementary Open-ended Questionnaire Items

The researcher employed the use of content analysis to interpret and report on participants' responses to two open-ended questions that were collected through the on-line survey with carers. Content analysis is a method of analyzing written, verbal or visual communication messages, and it is commonly used in nursing studies (Elo & Kyngäs, 2008). As a research method, content analysis involves defining the content to be studied, the concepts to be measured, and the unit of analysis (Mcneese-Smith, 1999). The process of analysis is to make sense of the data (Moule et al., 2017). Data that were collected from the two open-ended questions located in on-line survey was subjected to content analysis. The content of the data was explored and reduced by the process of "coding" by this researcher. The themes that evolved were identified. The researcher's advisor (Dr. Lobchuk) participated in the content analyses of a random sample of open-ended responses to survey questions to assist in developing the coding template. Any disagreements in coding was resolved with further discussion between this researcher and Dr. Lobchuk.

Summary

This chapter outlined methods that were used to carry out a correlational, predictive study aimed to identify relationships among Predisposing, Enabling resources, and Need factors with the carer's intention to use health services as guided by Andersen's (1995) Behavioral Model of Health Service Use. The methodology, sample, sample recruitment protocol, setting, data collection instruments, and data analyses were presented. Ethical issues and confidentiality issues were addressed. Chapter Five presents the findings that emerged from this research study.

CHAPTER FIVE

RESULTS

The purpose of this study was to examine Chinese Canadian family carers' experiences with filial piety and decision-making about long-term care and home care services for their aging parents. This chapter provides a descriptive profile of family carer participants and their care recipients (i.e., their aging parents) based on demographic data collected. Statistical analyses of the research question were presented in conjunction with a report of major findings.

The specific research question was, "What is the association of Predisposing characteristics (e.g.., demographic characteristics, filial piety), Enabling resources (e.g., access to health services) and Need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making processes about long-term care?"

Family carer participants were recruited over a one-month period between September 2019 and October 2019 from Winnipeg, Manitoba. Data were collected on-line by administering to the participants a data demographic questionnaire, the Contemporary Filial Piety Scale (CFPS-10) (Lum et al., 2016), the Morycz's Desire-to-institutionalize Scale (DTI) (Mccaskill, Burgio, Decoster & Roff, 2011), and the Care Giver Burden Inventory (CBI) (Novak, Guest & Novak, 1989).

Summary of the Quantitative Findings

Demographic Data

In total, eighty-two family carers responded to the online survey. Twenty-one of these carers had consented to the study but did not answer any of the questionnaires. One carer called the researcher to explain that she did not proceed to complete the questionnaires as the questions did “not apply to her situation”. Sixty-one family carers completed the on-line questionnaires either in full or part-response. The demographic characteristics of the study participants are shown in Table 5.1. Typical family carers were: younger than 40 years of age (47.5%), female (80.3%), legally married or living common-law (90.2%), the daughter of the care recipient (60.7%), had had lived in Canada for 5 years and more (63.9%). Around 48 per cent of the carers lived with their care recipients and 44 per cent did not live with their care recipients. The majority of carers (93.4%) had graduated from college or university and were employed (70.5%). Most carers reported an annual income of more than $50,000 (63.9%). Most carers reported being a family carer for the past 5 years (63.9%).

Regarding care recipients, their mean age was 69.6 years; (SD = 9.7; range from 49 to 89 years of age). Most care recipients were not receiving formal home care services (95.1%). Only five participants (8.2%) answered “yes” to the question, “Do you know anything about home care?”. Most Chinese Canadian family carers who participated in this study reported that they spoke Mandarin (91.8%).

Table 5.1 Descriptive statistics of the study variables (n = 61 family carers).

Variables	Count	Mean (SD)	Percentage (%)
Carer age			
<40	29		47.5
41-50	19		31.1
>50	13		21.3
Carer gender			
Male	10		16.4

Female	49		80.3
Prefer not identify	2		3.3
Carer marital status			
Never married	4		6.6
Legally married/common law	55		90.2
Other	2		3.3
Carer relationship with CR			
Daughter	37		60.7
Son	8		13.1
Other	16		26.2
Carer time in Canada			
Less than 5 years	22		36.1
More than 5 years	39		63.9
Carer living arrangement			
Together with CR	29		47.5
Not together	27		44.3
Prefer not to identify	5		8.2
Carer education			
Less than college or university	4		6.6
College or University and above	57		93.4
Carer employment status			
Unemployed	12		19.7
Employed	43		70.5
Others	6		9.8
Carer annual income			
<$50,000	22		36.1
> $50,000	39		63.9
Carer years of being a family care			
<5 years	39		63.9
>5 years	16		26.2
Prefer not to identify	6		9.8
CR Age		69.6 (9.7)	
CR currently receiving home care			
Yes	3		4.9
No	58		95.1
Carer Do you know anything about home care			
Yes	5		8.2
No	56		91.8
Carer Language			
Mandarin	56		91.8
Cantonese	2		3.3

English	3	4.9
Carer Filial Piety (CFPS-10) (range: 10-50)	46.5 (4.2)	
Carer Burden Inventory (CBI) (range: 0-96)	16.4 (14.7)	
Carer Morycz's DTI scale (range: 0-6)	0.69 (1.37)	

Abbreviations: CR: Care recipient
For CFPS-10, the higher the score, the more important filial piety felt by the carer.
For CBI, the higher the score, the more burden felt by the carer.
For DTI, the higher the score, the greater the carer's desire to institutionalize the care recipient.

Reliability of Instruments

According to Tavakol and Dennick (2011), when evaluating a measurement instrument, validity and reliability are two fundamental elements to report. Instruments can measure concepts, psychomotor skills or affective values. Instruments that are unreliable do not provide appropriate or sufficient means to test values. Thus, knowledge regarding an instrument's reliability is very important when conducting and analyzing research (Polit & Beck, 2004). Cronbach's alpha coefficient is the most frequently utilized measure of reliability when multiple-item measures of a concept or construct are employed (Polit & Beck, 2004). It used to measure reliability and internal consistency of the instrument. The instruments with Cronbach's alpha coefficients that are above .70 are considered sufficiently reliable; if the value is above .80, the instrument is considered to be highly reliable (Polit & Beck, 2004). Table 5.2 represents the calculated Cronbach's alpha coefficient results for this study's instruments that demonstrate acceptable reliability.

Table 5.2 Reliability of instruments

Instrument	Cronbach's Alpha
Carer Filial Piety (range: 10-50)	0.82
Carer Burden Inventory (range: 0-96)	0.95
Carer Morycz's DTI scale (range: 0-6)	0.82

The Contemporary Filial Piety Scale (CFPS-10) was used to capture the practice of filial piety among Chinese Canadian family carer participants. A five-point Likert-type scale was used, with “1” unit indicating “not important” to “5” unit indicating “very important” (see Appendix D). Total scale scores can range from 10 (the lowest) to 50 (the highest) units. The mean CFPS-10 score in this study was 46.5 (SD 4.2).

The Care Giver Burden Inventory (CBI) was used to capture Chinese Canadian family carers’ felt burden (Appendix F). The CBI contains twenty-four items. Each statement had a five-point Likert-type scale that ranged from 0 (Never) to 4 (Nearly always). Total scale scores can range from 0 unit to 96 units. The higher the score, the more burden is felt by the carer. The mean value for CBI was 16.4 (SD 14.7).

The Morycz Desire-to-institutionalize Scale (DTI) (Appendix E) was used to assess Chinese Canadian family carers’ desire to institutionalize their elderly parents. The scale contains six items with dichotomous response options of ‘Yes’ (1)’ or ‘No’ (0). The DTI item scores ranged from 0 unit to 6 units; higher scores indicated a greater desire to institutionalize the care recipient.

Analysis

Research Question: What is the association of predisposing characteristics (e.g.., demographic characteristics, filial piety), enabling resources (e.g., access to health services) and need factors (e.g., level of carer burden) with the carer’s intention to use health services and their decision-making processes about long-term care?

To identify factors associated with the carer's intention to use health services and their decision-making processes about long term care, as captured on Morycz's DTI tool, this researcher employed both correlational analysis and tests of differences. Based on the normality test (Shapiro-Wilk), distribution of carer Morycz's DTI data failed ($p < 0.0001$) to meet the normal distribution and thus the non-parametric analysis were employed to test the differences and associations between study variables. Therefore, the Spearman's rank correlation coefficient analysis was conducted with the following continuous data: care recipient age, carer filial piety, carer burden inventory, and carer Morycz's DTI. The Mann-Whitney Rank Sum Test was used to compare categorical data with two levels: carer gender, carer marital status, carer time in Canada, carer living arrangement, carer education, carer employment status, carer annual income, carer years of being a family carer, CR currently receiving home care, and carer's knowledge about home care. The Kruskal Wallis H Test was used to test categorical data with three or more levels: carer age, carer relationship with CR, and carer language.

Results

Spearman's Rank Correlation Coefficient Analyses. Correlation is used to study relationships, and it provides a measure of the strength and direction of the relationship between variables (Plichta et al., 2013). The Spearman's rank test showed that the carer's intention to use long-term care (as measured on Morycz's DTI) was not significantly correlated with any measured continuous variables including care recipient age ($p = 0.533$), carer filial piety ($p = 0.201$), carer burden inventory ($p = 0.122$).

Mann-Whitney Rank Sum Test. The Mann-Whitney Rank Sum Test indicated that carer Morycz's DTI was significantly greater for male (Mdn = 2) than for female (Mdn = 0) carers, U = 101, p = 0.043. Otherwise, there was no significant difference in carer Morycz's DTI in relation to the other variables such as carer marital status, carer time in Canada, carer living arrangement, carer education, carer employment status, carer annual income, carer years of being a family care, CR currently receiving home care, and carer's knowledge about home care.

Kruskal-Wallis H test. The Kruskal-Wallis H test was conducted to compare the carer's intention to use long-term care for categorical variable with three or more levels. There was no statistically significant difference found between carers' responses on Morycz's DTI as influenced by different carer relationships with the care recipient, (H (2) = 5.438, p = 0.066); the mean rank scores were 25.0 for sons, 21.9 for daughters, and 32.9 for other related individuals. As part of an exploratory analysis, the researcher set the significance level at $p < 0.1$ (a borderline level of statistical significance) to identify variables that might be in partial relationships as identified in a regression model. In other words, the researcher included all variables in the regression model that had a p-value of < 0.01 in the univariate analysis. The only borderline variable included in the regression model (in addition to carer gender that had a statistically significant relationship with DTI) was the "other" relationship which describes two sons-in-law and three daughters- in-law. The carers' intention to use long-term care was not affected by carer age (p = 0.904) or carer language (p = 0.363).

General Multiple Linear Regression. According to Segrin (2010), multiple regression is a flexible statistical method for analyzing associations between two or more independent variables and a single dependent variable. It can be used to test scientific hypotheses about whether and to what extent certain independent variables explain variation in a dependent variable of interest. Multiple regression is most commonly used to predict values of a criterion variable based on linear associations with predictor variables (Segrin, 2010). In this study, a multiple regression analysis was calculated to predict the carer's intention to use long-term care facility for their care recipient (as captured on Morycz's DTI) based on carer gender (significant) and carer relationship with CR (borderline significant). In this analysis, participants' intention to use (Morycz's DTI) was the dependent variable. Independent variables included carer gender and carer relationship with CR.

A significant regression equation was found (F (2, 43) = 6.262, p = 0.004), with a R^2 of 0.226. The predicted carer's intention to use long-term care facility is equal to 2.179 - (1.679 * CG Gender) + (0.833 * Carer relationship with CR), where Carer gender is coded as 1 = male, 2 = female, and Carer relationship with CR is coded as 1 = son, 2 = daughter, 3 = others. In other words, carer gender and the carer relationship explained 23% of the variability in carer's intention to use long-term services (see Table 5.3 below).

Table 5.3 Multiple regression selection model for the intention to use long-term care facility (Morycz's DTI, n=61).

Variable	*P*	Coefficient	Std. error	Model R^2
Carer gender	0.005	-1.679	0.568	0.226
Carer relationship with CR	0.026	0.833	0.362	
Constant	0.082	2.179	1.225	

Summary of Open-ended Questions

At the end of the demographic questionnaire, two open-ended questions were posed to participants: Question #1 was. “What are some barriers that do not help you to make a decision about long-term care and use of home care services for your loved one?” and Question #2 was, “What are some facilitators that help you to make a decision about long-term care and use of home care services for your loved one?”. Among the 61 participants, 29 participants responded to Question #1 and 21 participants responded to Question #2. Analysis revealed that almost all of the participants responded with a single word or few word responses. For example, the participant would just say, “finances/cost” in response to the barriers question. No explanatory text or narrative was provided to explain why they answered the way they did.

Based on the similarity of content in participant responses, this researcher merged participants’ responses to barriers and facilitators under five respective code categories of Finances or Costs, Filial responsibility / Cultural expectations, Language, need for Information, and Social Support and Assistance to reflect barriers and facilitators. Together with this researcher’s thesis supervisor (Dr. Michelle Lobchuk), the following code categories were defined and participant responses are provided to illustrate respective categories.

Code Category #1: Finances or Costs (n = 6)

This code category reflects statements provided by family carers that suggest cost or personal finances as barriers or facilitators either for the caregiver or the care recipient. Most responses were briefly stated: e.g., one participant simply said, “economic factors”. These statements reflected finances or costs as a barrier or a facilitator in helping the family caregiver to make a decision about long-term care and use of home care services for the care recipient.

Code Category #2: Filial Responsibility / Cultural Expectations (n = 8)

This code category reflects statements provided by family carers that suggest the positive or negative impact of family or cultural expectations, agreements, and or understanding about the long-term care of the care recipient in the community. One participant briefly stated, “filial responsibility” and another said, “traditional culture”.

Code Category #3: Language (n = 6)

This code category was about family carers perceptions that language posed as a barrier or a facilitator in relation to decision-making about long-term care or home care of their care recipient. Simple statements were offered by family carers: e.g., “language barrier”. Among the barriers, one carer identified language as a barrier for care recipients: e.g., “language barrier of the care recipient”. Family carers worried that due to the language barrier, the care recipient may not feel comfortable in long-term care facility. Some participants identified the carer’s language as a barrier in making a decision about long-term care and use of home care services for the care recipient: “language is a barrier for him/her to access to the long-term care service provided”. Other participants indicated that if professional care providers in long-term care facilities or home care services can speak Mandarin, this would serve as facilitator in helping them to make a decision about long-term care for the care recipient.

Code Category #4: Need for Information (n = 13)

This category reflects statements provided by family carers that describe how the lack of information about long-term care facilities and home care services can pose as a barrier in helping the family carer to make a decision about long-term care and use of home care services for the care recipient. The majority of the participants immigrated to Canada within the last five years, and they are not familiar with the health care system: e.g., we "need more information".

Code Category #5: Social Support and Assistance (n = 12)

This last code category reflects statements provided by family carers that suggest social support and assistance are very important to them when they make decisions about long-term care for the care recipient. Some participants indicated that if they could not take care of their parents at home due to the care recipient's health condition, participants would make the decision to admit their parents to a long-term care facility: e.g., "when parents are healthy, there is no need to send them to nursing home". Some of the participants indicated that even their parents are living with them and in need of some level of care, they would be willing to continue to care for their parent in the home. Most of the carer participants did not feel stressed from the carer role or have the urge to make an immediate decision about placing their parent in a long-term care facility.

Summary

Overall, this researcher attempted to answer the following research: "What is the association of Predisposing characteristics (e.g.., demographic characteristics, filial piety), Enabling resources (e.g., access to health services) and Need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making processes about long-term care?". To answer this question, this researcher was guided by Andersen's

Behavioural Model and its Predisposing, Enabling resources, and Need factor factors. Quantitative findings suggested that only the Predisposing factor of carer gender was significantly correlated with the carer's decision to institutionalize their parents. More specifically, female Chinese Canadian family carers were less likely to use long-term care facility. A borderline significant relationship ($p < 0.1$) was found between carer relationship to the care recipient (a Predisposing factor) and use of a long-term care facility. Overall, female Chinese Canadian family carers appeared to be less likely to use long-term care facilities and potentially, carers who were in an 'in-law' relationship with the care recipient were more likely to use long-term care facilities.

Two open-ended survey questions revealed that the lack of information held by family carers was a major barrier for carer decision-making about institutionalization of the care recipient. Content analysis revealed that social support, language barriers, cultural expectations, and finances all played an important role as barriers or facilitators in family carers' decision-making process.

This researcher will discuss the results in the following chapter.

CHAPTER SIX

DISCUSSION

This study was designed to examine Chinese Canadian family carers' experiences with filial piety and decision-making about long-term care and home care services for their aging parents. In total, 61 family carers participated in this study. The conceptual framework by Andersen (1995) provided the foundation for theconceptualization of this study. Andersen's Behavioral Model is mostly used for investigating health services utilization. In the current study, Andersen's Model was used to examine the intent of Chinese Canadian family carers to use long-term care for their elderly care recipients by exploring the relationships among Predisposing factors (i.e., demographic characteristic, filial piety), Enabling characteristics (e.g., access to health services), and Need factors (level of carer burden) and the Morycz's Desire-to-institutionalize Scale (DTI).

Major findings are interpreted in this chapter and subsequent conclusions are presented. A description of the study's limitations, nursing practice implications and recommendations for further research are offered.

Discussion of the Findings

First, this researcher will discuss how representative the current study's sample of 61 Chinese family carers is in relation to Chinese family carers in Canada. In relation to understanding the 'typical' sample size of Chinese Canadian carers who participate in studies, evidence indicates that most sample sizes tend to be less than 50 participants. For example, Xiong et al. (2018) studied the needs and preferences for technology use with 40 Chinese family carer participants. Sethi et al. (2017) conducted a study in southern Ontario to describe the dual carer-employee role experiences with 13 Chinese Canadian carers.

According to Statistics Canada (2020), about 7.8 million Canadians reported in 2018 that, in the past year, they had cared for or helped a family member or friend who had a long-term health condition, or a physical or mental disability, or problems related to aging. The researcher was not able to locate a statistical profile of Chinese Canadian family carers who were caring for a family member or a friend with an illness, disability, or aging-related condition. Therefore, this researcher will describe the current study's sample of Chinese Canadian family carers in comparison to the wider Canadian sub-population of family carers.

According to Statistics Canada (2020), 61% of the family carers who were caring for parents were aged 45 to 64 years. In this study, the typical family carer was less than 40 years of age (47.5%); 31.1% carers aged 41-50 years, and 21.3% were 50 years and older. The participants in this study are younger than the general population of Canadian carers. A contributing factor toward this difference is likely due to the cultural value of filial piety and the Law of the People's Republic of China where adult children can feel obligated to look after their parents, even in Canada. As this researcher discussed in Chapter two, the law of the People's Republic of China on Protection of the Rights and Interests of the Elderly specifies that children of elderly or older persons are under legal obligation to provide for the elderly; i.e., they "shall fulfill the obligations of providing for the elderly economically, taking care of them in daily life and comforting them mentally, and attend to their special needs" (Order No. 24 of the President of the People's Republic of China, 2015).

This current study revealed that 47.5% of the Chinese Canadian carers were living with care recipients. This percentage is higher than that of the general Canadian family carer population. Statistics Canada (2013) stated that approximately three-quarters (73%) of carers indicated that they did not live with the same household or building as their care receiver. The reason for this observed difference is also likely due to cultural or financial reasons. During the data collection process, this researcher received a phone call from a Chinese older adult who was a care recipient living with his son. According to him, he was sponsored by his son to immigrate to Canada five years ago. He stated that due to government policy, he did not receive social welfare during the first 20 years of living in Canada. This individual was financially dependent on his son and unable to live alone. This researcher was unable to identify statistics on the number of Chinese older adults who come to Canada by sponsorship. According to Immigration Canada (2020), a sponsor is financially responsible for the first 20 years after the person they sponsored to become a permanent resident. As far as the researcher know, an immigrant senior is eligible for OAS and GIS and qualified for 55+ housing, after having lived for 10 years in Canada. However, they are still financially dependent during the first 10 years of living in Canada. This researcher has knowledge of experiences similar to this individual's account based on her personal connections in the community with Chinese seniors who immigrate to Canada by sponsorship.

In the current study, most of the Chinese Canadian family carers were legally married or in a common-law relationship (90.2%). According to Statistics Canada (2013), 65% of the Canadian carers reported being in a married or a common-law union. The employment rate of Chinese Canadian family carers was slightly higher (70.5%) than Canadian family carers (60%). There are comparable income levels reported by 63.9% of Chinese Canadian family carers who had an annual income of greater than $50,000; 53% of Canadian family carers reported that they earned greater than $60,000 per year and 22% within the range of $40,000 to $59,000 (Statistics Canada, 2015). Statistics Canada (2020) revealed that in 2018, about 70% of caregivers reported that they received support for their caregiving duties from at least one of the nine sources; 67% of caregivers reported receiving some type of social support and 22% reported receiving some type of financial support. In the current study, only 4.9% of the participants reported that they are receiving home care services for their care recipient, and 91.8% reported that they did not know a lot about home care services.

The current study sample consisted mainly of female carers (80.3%). Similarly, Statistics Canada (2020) identified that women represented the majority of carers in Canada (54%). The results of the current study are similar to related literature where Chinese Canadian family carers are typically females and the daughter of care recipients (Lai et al., 2007). These results challenge the Chinese male-dominated culture and gender roles with family caregiving. Traditionally, sons make caregiving decisions in the household, and daughters-in-law are the designated primary carer. Dr. Lai and colleagues' study findings also revealed that daughters are the largest group of carers among Chinese Canadian family carers who take the lead in making care decisions for their relatives (Lai et al., 2007). This finding will be discussed further below.

Next, the researcher will discuss key findings that address the research question, "What is the association of Predisposing characteristics (e.g., demographic characteristics, filial piety), Enabling resources (e.g., access to health services) and Need factors (e.g., level of carer burden) with the carer's intention to use health services and their decision-making processes about long-term care?" The only significant factor found in association with intention to use health services by the carer was the predisposing factor of care gender. The enabling factor of carer relationship with the care recipient had a borderline significant association ($p < 0.1$) with intention to use health services by carers. The association between carer gender and carer relationship with the care recipient and the carer's intention to use health services will be discussed next.

Gender

As guided by Andersen's Model, carer gender was the only significant Predisposing factor related to the carer's intention to use long-term care facility for the care recipient. To be more specific, female Chinese Canadian family carers were less likely to use long-term care facility. This researcher views this to be a complex relationship that is likely impacted by a mixture of influential factors related to traditional values (filial piety) and Western values (engagement in other meaningful societal roles like employment status). For instance, a number of related studies reported on Canadian Chinese female carers' simultaneous reports of high levels of self-esteem and carer burden. Chappell et al. (2015) studied carers in British Columbia and compared carer burden as reported by caregiving women, caregiving men, caregiving spouses and caregiving adult children. Their results revealed that "daughters experience the highest burden but also the highest self-esteem, suggesting the role is less salient for their self-identities." (Chappell et al 2015. p. 623). In other words, despite female carers' reports of high burden associated with the caregiving role, it is likely that these women experienced high levels of self-esteem as derived from other aspects they find fulfilling about their lives (e.g., other societal roles). It is plausible that female carers in the current study also experienced sufficient satisfaction in their other roles that enabled them to continue to fulfill their caregiving role in the community. Unfortunately, in the current study, carer self-esteem was not measured and female Chinese Canadian carers were not asked further about their other roles that may have influenced their intention to not use long-term care facilities at the time of this study's survey.

Dr. Lai (2008) conducted a study in Calgary where he reported on Chinese Canadian family carers' intention to use home support services. According to Lai (2008), the majority (65.5%) of family carers in his sample were females who were more likely to consider using home support services than male carers. In relation to the current study's findings, it is plausible that female carers would also consider using home support services versus long-term care facilities for their care recipient. Statistics Canada (2020) reported that women are more likely to report receiving support for caregiving. It is unfortunate that carers in the current study were not asked about their intention to use home care supports in addition to their future use of long-term care facilities for the care recipient. This researcher believes, nonetheless, that female carers in the current study's sample would also be willing to receive home support services to enable care in the home versus using a long-term care facility for care recipient.

The Chinese tradition is for female relatives to engage in hands-on and personal care for aged or informed care recipients that warrants further discussion in the context of this current study's findings. As described earlier, traditionally females who marry into a male's family were not given a choice to take care of their own parents. Male relatives (e.g., a son) will take the lead in deciding how their wife will care for parents. On the other hand, in Canada, when Chinese Canadian female carers need to make a choice between providing care to their own parents and their parents-in-law, daughters are more likely to choose to be the primary carer for their parents (Lai et al. 2007). Dr. Lai explained that the reason for why Chinese daughters-in-law in Canada no longer embrace the traditional gendered caregiving role is related to their socialization into Western society. Immigrant women likely experience a shift in their cultural values and beliefs where they no longer automatically or wholeheartedly accept traditional gendered caregiving roles associated with their husbands who are sons of parents. Instead, many Chinese Canadian daughters see themselves as primary carers for their own aging parents and not necessarily primary carers for their parents-in-law (Lai et al, 2007).

In the context of general decision-making about care matters (i.e., besides about long-term use of facilities) in Canada, Lai et al. (2007) found that elderly wives in Canada were more likely to be the individual who made care decisions within the context of their relationship. When the spouse is not available, daughters are the predominant care providers who make decisions about care provision for the care recipient. Overall, this study's findings suggest there is a shift in cultural values where Chinese Canadian female carers take the lead in making decisions about 'what' relative they will care for and what care services are deemed optimal for their relative.

Relationship

Although there was only a trend ($p < 0.1$) toward a significant relationship between the Enabling factor of the care relationship with the care recipient and carer intention to use long-term facilities, this researcher will explore plausible reasons for this finding. In other words, Chinese Canadian family carers are more likely to use long-term care facility for their care recipient if they are in a “in-law” relationship with the care recipient. This result is consistent with Statistics Canada’s (2013) where adult children were almost four times more likely to report caring for a parent than a parent-in-law. The Chinese tradition is for female relatives to engage in caregiving for relatives regardless of the relationship to the care recipient. However, this researcher found the Chinese Canadian female carers were being more selective in terms of ‘who’ they will provide care to in the family unit. This result challenges the traditional Chinese male-dominated culture where sons make caregiving decisions in the household and where daughters-in-law are designated as the primary carer to an in-law parent. A related recent study of family carers in mainland China also had similar results. Warmenhoven et al. (2018) observed that due to economic development, traditional values in China are slowly disappearing. Women are gradually harnessing decision-making power in marriages and garnering greater economic leverage that is resulting in changing filial practices by women toward their marital parents. This researcher believes that in a larger study sample, a significant relationship would have been found between female Chinese Canadian carers reporting increased intention to use long-term care services for their in-law versus natural parents.

Exploring Non-existent Relationships as Depicted in Andersen’s Model

According to Lai’s (2008) study findings, filial piety was a significant predictor of carers’ use of long-term care facilities for care recipients. However, in the current study a significant relationship was not found. To speculate on reasons for this non-relationship, it is important to recognize that the mean score on the Carer Filial Piety scale (theoretical score range is from 10 to 50 units) was 46.5 units. This high filial piety mean score reflects the degree to which this study’s sample of Chinese Canadian family carers value filial piety. Moreover, this study’s sample of Chinese Canadian family carers also reported a low mean level of carer burden (mean score of 16.4 units; the theoretical score range was 0 to 96 units; higher scores indicate more burden) and a low intention to use a long-term care facility (mean score of 0.63; theoretical score range was 0 to 6 units; higher scores indicate greater intention to use long-term facilities). During the data collection process, this researcher received numerous phone calls from carers who described that many of the study questions were not relevant to them because their care recipient was still relatively independent. Moreover, these carers said that they did not feel any carer burden (e.g., “I don’t feel the care recipient’s health status is a burden, the question does not apply to my situation”) and did not feel that the question about intending to use long-term facilities applied to them within the last 6 months of completing the study questionnaires. Carer responses to open-ended questions also revealed that they were not considering long-term care facilities at the time of the study; e.g., “when parents are healthy, there is no need to send them to nursing home”. Overall, there was limited variability in carer responses on filial piety, carer burden, and carer intention to use long-term facilities that likely contributed toward insignificant relationships found among these study variables.

Overall, there was only one significant study finding where carer gender, as a Predisposing factor, was related to carer intention to use long-term facilities for the care of the care recipient. This finding provides supportive evidence for this relationship as depicted in Andersen’s Model. There was one finding of borderline significance between the carer’s relationship to the care recipient (an Enabling factor) and intention to use long-term care facilities. Due to the limited variability in carer burden, carer filial piety, and carer intention to use long-term care facilities, no further significant relationships were found in support of Andersen's Model. With only one significant univariate relationship found between carer gender and intention to use long-term facilities, multiple regression analysis results are not discussed further here.

Open-ended Questions

Participants were asked to respond to two open-ended questions: "What are some barriers that do not help you to make a decision about long-term care and use of home care services for your loved one?" and "What are some facilitators that help you to make a decision about long-term care and use of home care services for your loved one?" This researcher found additional barriers and facilitators that family carers briefly described as being influential on their decision-making about institutionalizing the care recipient. First, participants identified that the lack of information about available long-term care services and home care services is a major barrier when comes to the decision making about institutionalizing care recipients. Other factors such as social support, language barriers, cultural expectations, and family carer and care recipient finances played important roles on family carers' decision making processes.

This researcher found that most of the written responses of barrier and facilitator factors for decision-making about institutionalizing the care recipient can be categorized according to Andersen's Model. For instance, the care recipient's age, gender, and filial piety belong to Predisposing characteristics. Family carer reports about the financial situation of the care recipient and family carers, language barriers experienced by the family carer and/or the care recipient, and the family carer lacking information about available home care and long-term care services can be identified as Enabling resources according to Andersen’s Model. Social support and assistance required by the family carer to properly care for the care recipient in the home setting can be considered Need factors according to Andersen (1995). The results of the open-ended questions suggested that the Predisposing factors, the Enabling factors, and Need factors all played an important role in the current study’s sample of Chinese Canadian family carers in their decision making processes.

Participants’ responses to the open-ended questions suggested that finances, filial piety, need for further information, social support, and language barriers were salient facilitators or barriers to their decision-making about long-term use of facilities for the care recipient. However, when most of these factors were quantitatively captured and statistically tested with carer intention, there were no significant findings found. The lack of significant findings is likely related to participants’ limited variability in responses to many of the survey questions; e.g., intention to use long-term facilities was on average low in this study’s sample of family carers. It is also plausible that the word tense of the questionnaires might have made this study’s sample of family carers to view this study’s questionnaire items as being irrelevant to their current situation. For example, the Morycz’s Desire-to-Institutionalize Scale (Appendix E) consisted of six questionnaires, all of which started with the word stem: “In the past 6 months, have you…” Based on this researcher’s communication with many of the study participants, family carers explained that they had not contemplated long-term care or home care services over the past six months due to the relative stable status of their relative. However, if the questionnaire stem was reworded to reflect the carer’s thinking about their relative’s care in the future (e.g., “For the future, have you….”), there may have been significant relationships found.

Several of the participants' open-ended responses about barriers and facilitators to their decision-making support previous findings by other researchers. For instance, several participants briefly stated that due to filial piety, they would not consider using long-term care facilities or home care services for their care recipient. Lee and Sung (1997) found that the willingness of the adult child to provide direct care to their parent was associated with filial piety. Furthermore, Awasthi and Awasthi (2017) stated that the role of filial piety in caregiving can be positive or negative. For instance, some carers derive satisfaction and a high level of self-esteem from caregiving because of high filial piety. Other carers experience burden if this is perceived as an obligation that needs to be fulfilled for the sake of face-saving. Awasthi and Awasthi (2017) described that filial piety can affect the caregiving arrangement and the caregiving experiences of carers in terms of psychological variables (e.g., guilt, depression, sadness).

Participants' responses also indicated that some Enabling factors like language barriers, a lack of information about the health care system and community resources, and the need for better social supports and assistance were also important to Chinese Canadian carers during their decision making process. These findings are consistent with those described by Facts (2006) who conducted a study in Calgary about barriers faced by Chinese carers when accessing social services. Fact's (2006) findings showed that the five most commonly reported barriers were: being too long on a wait list (64.4%), professionals who do not speak the service user's language (61.3%), services were not specialized for the Chinese community (59.7%), professionals who do not understand the Chinese culture (56.8), and service providers who are not themselves Chinese (53%)." Of note, despite Fast's (2006) having been conducted 14 years ago, many of these barriers still exist for Chinese Canadian family carers according to the current study's findings.

Kim and Lee (2016) conducted a similar study in Korea using Andersen's Behavioral Model to study the general experiences of health services utilization by family carers. These researchers examined Predisposing, Enabling, and Need factors that determine the overall health services utilization experiences of outpatients and inpatients in the National Health and Social Affairs. Their findings revealed that "the health services utilization was more significantly explained by Predisposing and Need factors than Enabling factors" (Kim & Lee, 2016, p. 18). In the current study, there was one quantitatively significant Predisposing factor (i.e., carer gender), and qualitative reports of one Predisposing (i.e., filial piety), three Enabling (i.e., language, need for information about available services, social support) and one Need (i.e., finances) factors that influenced carer decision-making as found by Kim and Lee (2016) and as depicted in Andersen's Model.

The following will entail the researcher's further speculation on the lack of significant associations found between some Predisposing, Enabling, and Need factors with DTI. First, with carer burden (a Need factor according to Andersen's Model), the researcher did not target family carers of care recipients dealing with specific types or degrees of illness but rather included all family carers who provided some level of care in the community to care recipients. It would have been beneficial to include family carers who were dealing with more serious conditions (i.e., due to a heavy symptom load or decreased functional status of care recipients) to explore the relationship between carer burden and decision-making about long-term and home care services.

With regard to age, identified as a Predisposing factor according to Andersen's Model, care recipients in this study were on average 70 years of age. Several participants described that, "my parents are still healthy, don't need long-term care" and "my parents need help, but are relatively healthy at this point". These written responses by family carers appeared to be related to care recipient's age and stable health status that, in turn, explained carers' low reports of burden as captured on the Carer Burden Inventory tool. On the other hand, when family carers were asked about facilitating factors that would help them to make a decision about long-term care and use of home care services for your loved one, seven participants described that, regardless of care recipient age, when the care recipient's health condition deteriorated to a point beyond their ability to provide optimal care to their loved one, they would consider options for accessible social support and care assistance. Overall, the findings indicated that due to the 'relatively' young age of care recipients and stable health status, most family carer participants were not in a situation to engage in decision-making about long-term care or home care services for their relative. However, family carer open-ended responses also indicated that in the future should the aging care recipient's health deteriorate, they would consider available community services and long-term care for their loved ones.

In summary, there was one significant Predisposing factor of carer gender in relation to the carer's intention to use long-term care facility for the care recipients. The carer's relationship with the care recipient was found to have a borderline significant relationship with intention to use long-term care facility. Based on shifting values of Chinese Canadian carers in western society, the researcher discussed how carer gender and the carer's relationship with the care recipient can influence the carer's decision-making about long-term institutionalization and home care services. as supported by related literature. Overall, study findings provide evidence in support of Andersen's Model and the relationship between the Predisposing factor of carer gender and the carer's decision-making processes about institutionalization of their care recipient.

Limitations of the Study

The researcher has identified several limitations of this study that will be addressed. First, the generalizability of this study is limited by the small sample of 61 family carers who were recruited by online survey. All the participants were from the same urban community in the City of Winnipeg that makes it difficult to generalize study findings to other communities (e.g., Chinese Canadian living in rural areas).

Second, the participants were asked to complete on-line questionnaires where some participations did not completely answer the survey questions. Other participants contacted the researcher and explained that, "the questions did not apply to my situation" because the care recipient was relatively young in age and was not in need of a lot of care as supported by low reports of carer burden by family carers on the Morycz DTI tool and the Care Burden Inventory. Family carer responses to the open-ended survey questions about facilitators and barriers were generally brief. It is likely that face-to-face interviews with family carers would have resulted in more fulsome responses to the open-ended survey questions. As well, it is possible that family carers who did not have access to a phone or a computer were not able to participate in this online study. It appears that the generalizability of study findings is limited to a younger Canadian Chinese family carer population who have access to a phone or a computer. It is also well known from the Canadian literature that family carers in general are a stressed population who may not have time or be motivated to complete the on-line questions.

Another limitation concerned the appropriateness of this researcher's use of one tool that captured carers' decison-making about the institutionalization of the care recipient to long-term care. Although carers were asked opened questions about facilitators and barriers impacting carer decision-making about the use of long-term care and home care services, it would have been helpful to also employ an additional tool that captured decision-making about community services (besides institutionalization to long-term care facilities) to help keep the care recipient in the home; e.g., the Community Service Attitude Inventory (CSAI) (Appendix H) tool. This researcher had initially planned to include this tool as part of the data collection protocol (as described in the Methods chapter). However, the cost of purchasing this tool was prohibitive to this researcher who did not have research funds to acquire the tool. Nonetheless, when considering the current health status of the care recipients and traditional values (filial piety) of family carers included in this study, it would have been appropriate to pose questions to carers about their decision-making on community care in the home setting.

Despite the noted caveats on the generalizability of the current study's findings, a main strength lies in this researcher being able to provide more recent evidence on Chinese Canadian family carers' decision-making processes regarding the use of health care services for care recipients. Most of the participants in this study were newly immigrated to Canada (within the past five years), which also provides valuable information about the Chinese Canadian family carer population and their informational needs to make care decisions about their relative. This study also provides some insights on gender differences in the decision-making process of family carers about ‘future’ care for care recipients.

Implications for Nursing Practice

This study’s findings have several implications for the nursing care and support of Chinese Canadian family carers. First, the high filial piety score in this study indicates that most Chinese Canadian family carers in this study’s sample retain their traditional values on the care of their aging parents. However, Lai (2007) described that a sense of filial piety may be beneficial to the wellbeing of some carers, while harmful to other carers. Due to the lack of variability in this study sample of family carer reports of carer burden and carer filial piety, this researcher was not able to confirm the existence of a relationship between carer burden and filial piety with carer decision-making about institutional care and home care services as captured in previous research (e.g., Lai, 2007). Nonetheless, nurses need to engage in sensitive conversations with Chinese Canadian family carers when discussing caregiving issues and decision-making about the care of care recipients.

Second, health care workers including nurses need to be aware of the influence of carer gender on considering long-term care and service use for care recipients by Chinese Canadian family carers. In other words, this study’s findings suggest that nurses need to be aware that female Chinese Canadian family carers are less likely to use long-term facilities for their care recipient. Nurses can develop care interventions that can support female carers by providing them with information about care options in the community to help them make appropriate decisions about future care of the care recipient. Although the carer’s relationship to the care recipient revealed a trend toward being significantly related to their decision-making processes about health service use, nurses still need to be aware of Chinese traditions about gender and relationship rules and how the values of Chinese Canadian caregivers can evolve over time and become influenced by western society; i.e., where Chinese Canadian adult children experience a reduced acceptance of Chinese traditions about roles in family caregiving.

Third, in their written responses about barriers and facilitators in their decision-making about health service use for the care recipient, family carers identified that their lack of information on options for care in the community plus language barriers were major issues. Many of the study participants described barriers and facilitators as modifiable factors that nurses can address in their support of Chinese Canadian family carers' decision making processes. This researcher summarizes the following options derived from participant responses for nurses to better support Chinese Canadian family carers:

1. Nurses should be provided with opportunities to engage in continuing education on the provision of culturally appropriate care (e.g., inclusive of content on filial piety and cultural practices and expectations about family caregiving roles).

2. Nurses should supply family carers with educational materials that can be understood by family carers (i.e., translated evidence in a language that is understood by Chinese Canadian family carers) when English is not their first language.

3. Nurses should identify cultural resources within their respective care institutions or in the community that can help Chinese Canadian family carers to understand care options and then make appropriate care decisions for their care recipients.

4. Nurses need to understand that, due to filial piety, their decision to place parents into long-term care facilities can cause some guilt or other psychological distress to Chinese

Canadian carers and need to be addressed (i.e, reliable assessment or identification followed by recommendations for relevant social support or counselling services in the community).

Recommendations for Future Research

Future research needs to include a larger sample size to engage in more rigorous, systematic testing of relationships depicted in Andersen's Model about decision-making by family carers on institutionalization and health service use for care recipients. Multi-site studies could also be helpful in studying geographic or regional factors (e.g., available supports or resources) that influence Chinese Canadian family carer intentions to institutionalize care recipients.

The Morycz's DTI scale was not appropriate to employ with this study's participants due to the wellness state and relatively young age of the care recipients. For future studies, this researcher recommends the careful selection of tools that capture intention to use health care services that are appropriate for carers to respond to (e.g., depending on the age, disability level, or illness state of the care recipient). Furthermore, researchers need to develop more comprehensive tools to capture the range of health care services that family carers contemplate for the appropriate care of their care recipients. This researcher considered the Community Service Attitude Inventory (CSAI) (Appendix H) to capture family carer participants' attitudes toward using community services. However, the CSAI was very broad and unclear as to what is meant by 'community services'. It is recommended that researchers need to clearly define 'community services' and explain this definition to study participants when asked to consider the types of community services for the care of their relative.

Ongoing research on respective characteristics of the care recipient, family carer, and the caregiving situation could help in developing a profile of factors for nurses to draw on to more readily identify Chinese Canadian family carers in need of support and resources to make satisfactory decisions about the ongoing care of the care recipient. For example, future studies can include combinations of younger and older generations of family carers and care recipients to uncover generational influences on carer-care recipient dynamics in their decision-making processes. Finally, this researcher recommends conducting mixed design studies that incorporate quantitative and qualitative responses of family carers. In particular, conducting more in-depth qualitative interviews with family carers would provide greater insights about barriers and facilitators they encounter in their decision-making processes.

Conclusion

With growing numbers of Chinese Canadians living in Canada and in caregiver roles, more evidence on their decision-making processes in the care of ill, disabled, or aging significant others is required by nurses in the care of these individuals. The researcher discussed her study findings on carer gender and the carer relationship to the care recipient as potentially influential factors on family care decision-making processes about health service use. Implications for nursing care were discussed based on family carer responses in the current study. Caveats were described in relation to limited generalizability of study’s findings due to the small sample size, challenges in collecting fulsome responses by carers in their online responses to study questions, and the recruitment of participants from one geographic location. There was also limited variability on family carer responses to carer burden and filial piety that likely contributed toward limited understanding of their potential relationship with decision-making processes about health care service use. Recommendations for future research are offered including conducting future studies using a larger sample size, multiple locations, and a range of family carer and care recipient characteristics, and caregiving situations (illness, degree of functional mobility).

REFERENCES

Andersen, R. (1968). *A behavioral model of families' use of health services.* Research Series No. 25. Center for Health Administration Studies, University of Chicago. Chicago.

Andersen, R. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior, 36*(1), 1-10. https://www.jstor.org/stable/2137284

Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly / Health and Society, 51*(1), 95-124.

Awasthi, K., & Awasthi, P. (2017). Effects of filial piety in the experiences of informal caregivers. *Indian Journal of Positive Psychology*, *8*(3), 447–449. http://search.proquest.com/docview/1962557541/

Bastawrous, M. (2012). Caregiver burden - A critical discussion. *International Journal of Nursing Studies, 50*(3), 431–441. https://doi.org/10.1016/j.ijnurstu.2012.10.005

Bradley, E., McGraw, S., Curry, L., Buckser, A., King, K., Kasl, S., & Andersen, R. (2002). Expanding the Andersen model: the role of psychosocial factors in long-term care use. *Health Services Research, 37*(5), 1221-1242. https://doi.org/10.1111/1475-6773.01053

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 1-8. https://doi.org/10.1177/2333393617742282

Burns, N., & Grove, S. (2003). *Understanding nursing research* (3rd ed.). Philadelphia: W. B. Saunders.

Caldwell, L., Low, L., & Brodaty, H. (2014). Caregivers' experience of the decision-making process for placing a person with dementia into a nursing home: comparing caregivers from Chinese ethnic minority with those from English-speaking backgrounds, *International Psychogeriatric, 26*(3), 413–424. https://doi.org/10.1017/S1041610213002020

Canadian Association of Retired Persons (2014). A New Vision of Aging for Canada. http://www.carp.ca/wp-content/uploads/2014/02/Caregiver-Brief-Feb-2014.pdf

Carers Canada. (2018). A Canadian carer strategy. http://www.carerscanada.ca/wp-content/uploads/2017/01/CC-Caregiver-Strategy_v4.pdf

Casarett, D., & Karlawish, J. (2000). Are special ethical guidelines needed for palliative care research? *Journal of Pain and Symptom Management, 20*(2), 130–139. https://doi.org/10.1016/s0885-3924(00)00164-0

Chang, Y. P., & Schneider, J. K. (2010). Decision-making process of nursing home placement among Chinese family caregivers. *Perspectives in Psychiatric Care, 46*(2), 108-118. https://doi.org/10.1111/j.1744-6163.2010.00246.x

Chang, Y., Schneider, J., & Sessanna, L. (2011). Decisional conflict among Chinese family caregivers regarding nursing home placement of older adults with dementia. *Journal of Aging Studies, 25*(4), 436-444. https://doi.org/10.1016/j.jaging.2011.05.001

Chappell, N. L. (2003). Correcting cross-cultural stereotypes: Aging in Shanghai and Canada. *Journal of Cross-Cultural Gerontology, 18*(2), 127-147. https://doi-org.uml.idm.oclc.org/10.1023/A:1025156501588

Chappell, N. L. (2008). Comparing caregivers to older adults in Shanghai. *Asian Journal of*

Gerontology & Geriatrics, 3(2), 57-65. http://www.hkag.org/Publications/AJGG/v3n2/p57_OA2008-43.pdf

Chappell, N., & Funk, L. (2011). Filial Caregivers; Diasporic Chinese Compared with Homeland and Hostland Caregivers. *Journal of Cross-Cultural Gerontology*, *26*(4), 315–329. https://doi.org/10.1007/s10823-011-9154-x

Chappell, N., & Kusch, k. (2007). The gendered nature of filial-piety a study among Chinese Canadian. *Journal of Cross-Cultural Gerontology, 22*, 29-45. https://doi.org/10.1007/s10823-006-9011-5

Chappell, N., Dujela, C., & Smith, A. (2015). Caregiver well-being: intersections of relationship and gender. *Research on Aging*, *37*(6), 623–645. https://doi.org/10.1177/0164027514549258

Chen, L. (2014). Deciding to institutionalize: caregiving crisis, intergenerational communication, and uncertainty management for elders and their children in Shanghai. *Journal of Gerontological Social Work, 58*(2), 128–148. https://doi.org/10.1080/01634372.2014.925026

Cheung, C. K., & Kwan, A. Y-H. (2009). The erosion of filial piety by modernization in Chinese cities. *Aging & Society, 29*, 179-198. https://doi.org/10.1017/S0144686X08007836

Cheung, C., Lee, J., & Chan, C. (1994). Explicating filial piety in relation to family cohesion. *Journal of Social Behavior and Personality, 9*(3), 565-580.

China Daily (2018). China's nursing homes more than triples in the past five years. http://www.chinadaily.com.cn/a/201802/22/WS5a8e7f2da3106e7dcc13d690.html

China Times (2018). China's elderly population to peek at half a billion in 2050. https://gbtimes.com/chinas-elderly-population-to-peak-at-half-a-billion-in-2050

Chou, K., Jiann-Chyun, L., & Chu, H. (2002). The Reliability and Validity of the Chinese Version of the Caregiver Burden Inventory. *Nursing Research, 51*(5), 324–331. https://doi.org/10.1097/00006199-200209000-00009

Chu, L. W., & Chi, I. (2008). Nursing Homes in China. *Journal of the American Medical Directors Association, 9*(4), 237-243. https://doi.org/10.1016/j.jamda.2008.01.008

Cohen-Mansfield, J., Dakheel-Ali, M., & Jensen, B. (2013). Predicting service use and intent to use services of older adult residents of two naturally occurring retirement communities. *Social Work Research, 37*(4), 313-326. https://doi.org/10.1093/swr/svt026.

Collins, C., Stommel. M., King. S., & Given. C.W. (1991). Assessment of the attitudes of family caregivers toward community services. *The Gerontologist, 31*(6), 756–761. https://doi.org/10.1093/geront/31.6.756

Cook, C. W. (1986). Chinese family law: A potential statutory revolution. *Loyola of Los Angeles International and Comparative Law Review, 9* (1), 63–80. https://digitalcommons.lmu.edu/ilr/vol9/iss1/3/

Creswell, J., & Poth, C. (2018). *Qualitative inquiry & research design: choosing among five approaches* (4th ed.). SAGE Publications, Inc.

Cronbach, L. (1970). *Essentials of psychological testing*. Harper & Row.

Dalton, J. (2003). Development and testing of the theory of collaborative decision-making in nursing practice for triads. *Journal of Advanced Nursing, 41*(1), 22-33.

https://doi.org/10.1046/j.1365-2648.2003.02502.x

Dalton, J. (2005). Client-caregiver-nurse coalition formation in decision-making situations during home visits. *Journal of Advanced Nursing, 52*(3), 291-299. https://doi.org/10.1111/j.1365-2648.2005.03589.x

Denzin, N., & Lincoln, Y. (2000). *The handbook of qualitative research* (2nd ed.). Thousand Oaks, Sage Publications.

Deutsch, F. M. (2006). Filial piety, patrilineality, and China's one-child policy. *Journal of Family Issues, 27*(3), 366-389. https://doi.org/ 10.1177/0192513X05283097

Edwards, S. B., Olson, K. M., Koop, P. C., & Northcott, H. (2012). Patient and family caregiver decision making in the context of advanced cancer. *Cancer Nursing, 35*(3), 178-186. https://doi.org/10.1097/NCC.0b013e31822786f6

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Facts. (2006). Service use barriers experienced by immigrant Chinese family caregivers. Hidden Costs/Invisible Contributions. Retrieved from: https://rapp.ualberta.ca/wp-content/uploads/sites/49/2018/04/2006CulturalBarriersToServiceUse.pdf

Farquhar, M. (2017) Is it time to create a new nurse role dedicated to helping carers? *Nursing Times, 113*(9), 39-41. Retrieved from: https://www.nursingtimes.net/roles/district-and-community-nurses/is-it-time-to-create-a-new-nurse-role-dedicated-to-helping-carers/7021028.article

Feng, Z. L., Zhan, H. J., Feng, X. T., Liu, C., Sun, M. Y., & Mor, V. (2011). An industry in the making: The emergence of institutional elder care in urban China. *Journal of the*

American Geriatrics Society, 59, 738-744. https://doi.org/10.1111/j.1532-5415.2011.03330.x

Fong, V. (2004). *Only hope: Coming of age under China's one-child policy*. Stanford University Press.

Funk, L., Chappell, N., & Liu, G. (2013). Associations Between Filial Responsibility and Caregiver Well-Being: Are There Differences by Cultural Group? *Research on Aging*, *35*(1), 78–95. https://doi.org/10.1177/0164027511422450

Gao W. (2017) New Chinese Migrants in Latin America: Trends and Patterns of Adaptation. In: Zhou M. (eds) Contemporary Chinese Diasporas. Palgrave, Singapore https://doi.org/10.1007/978-981-10-5595-9_15

Gaugler, J. E., Kane, R. L., Kane, R. A., Clay, T., & Newcomer, R. (2003). Caregiving and institutionalization of cognitively impaired older people: Utilizing dynamic predictors of change. *The Gerontologist, 43*(2), 219-229. https://doi.org.uml.idm.oclc.org/10.1093/geront/43.2.219

Goh, E. (2011). *China's one-child policy and multiple caregiving: Raising little suns in Xiamen.* NY: Routledge.

Government of Canada. (2018). Guide 5772- Application to Sponsor parents and grandparents. Retrieved from: https://www.canada.ca/en/immigration-refugees-citizenship/services/application/application-forms-guides/guide-5772-application-sponsor-parents-grandparents.html

Greenhalgh, S. (2005). Missile science, population science: the origins of China's one-child policy. *The China Quarterly, 182*, 253-276.

http://search.proquest.com/docview/59695829/

Hawley, S. T., & Morris, A. M. (2017). Cultural challenges to engaging patients in shared decision making. *Patient Educ Couns, 100*(1), 18-24. https://doi.org/10.1016/j.pec.2016.07.008

Holloway, I., & Galvin, K. (2017). *Qualitative research in nursing and healthcare* (4th ed.). Chichester, John Wiley & Sons Inc.

Home Health Care Agencies (HHCA). (2010). *Benefits of Home Health Care: Reasons to select home care as a senior care option.* Retrieved from: https://www.homehealthcareagencies.com/resources/benefits-of-home-care/

Horowitz, A. (1985). Sons and daughters as caregivers to older parents: Differences in role performance and consequences. *The Gerontologist, 25*(6), 612-617. https://doi.org/10.1093/geront/25.6.612

Hsueh, K. (2001). Family caregiving experience and health status among Chinese in the United States. https://repository.arizona.edu/handle/10150/279876

Hsueh, K., Hu, J., & Clarke-Ekong, S. (2008). Acculturation in filial practice among U.S. Chinese caregivers. *Qualitative Health Research, 18*(6), 775-785. https://doi.org/10.1177/1049732308318923

Hunt, M. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research, 19*(9), 1284-1292. https://doi.org/10.1177/1049732309344612

Immigration Canada (2020). How long am I financially responsible for the family member or relative I sponsor? Retrieved from: https://www.cic.gc.ca/english/helpcentre/answer.asp?qnum=1355&top=14

Jordan, D. K. (2005). Folk Filial Piety in Taiwan: The “Twenty-four Filial Exemplars”. Retrieved from: http://pages.ucsd.edu/~dkjordan/scriptorium/FilialExemplars.pdf

Keefe, J., Hawkins, G., & Fancey, P. (2006). A portrait of unpaid care in Nova Scotia. Healthy Balance Research Program.

Kempen, G. I. J. M., & Suurmeijer, P. B. M. (1991). Professional home care for the elderly: An application of the Andersen-Newman model in The Netherlands. *Social Science and Medicine, 33*(9), 1081-1089. https://doi.org/10.1016/0277-9536(91)90013-3

Kim, E. Y., Cho, E., & June, K. J. (2006). Factors influencing use of home care and nursing home. *Journal of Advance Nursing, 54*(4), 511-517. https://doi.org/10.1111/j.1365-2648.2006.03839.x

Kim, H., & Lee, M. (2016). Factors associated with health services utilization between the years 2010 and 2012 in Korea: using Andersen’s Behavioral model. *Osong Public Health and Research Perspectives, 7*(1), 18–25. https://doi.org/10.1016/j.phrp.2015.11.007

Kim, Y., & Kang, H. (2015). Effect of filial piety and intimacy on caregiving stress among Chinese adult married children living with parents. *Indian Journal of Science and Technology, 8*(s1), 434-439. https://doi.org/10.17485/ijst/2015/v8iS1/59361

Kissinger, H. (2011). *On China.* Allen Lane Canada.

Köhler, T., Landis, R., & Cortina, J. (2017). Establishing methodological rigor in quantitative management learning and education research the role of design, statistical methods, and reporting standards. *Academy of Management Learning & Education, 16*(2), 173–192. https://doi.org/10.5465/amle.2017.0079

Kurtz, M. E., Given, C. W., Given, B. A., & Kurtz, J. C. (1994). The interaction of age, symptoms, and survival status on physical and mental health of patients with cancer and their families. *Cancer, 74*(S7), 2071-2078.

Lai, D. (2008). Intention of use of long-term care facilities and home support services by Chinese-Canadian family caregivers. *Social Work in Health Care, 47*(3), 259–276. https://doi.org/10.1080/00981380801985382

Lai, D. W. (2004). Health status of older Chinese in Canada: Findings from the SF-36 health survey. *Canadian Journal of Public Health, 95*(3), 193-197. https://doi.org/10.1007/bf03403647

Lai, D. W. (2007). Cultural Predictors of Caregiving Burden of Chinese-Canadian Family Caregivers. *Canadian Journal on Aging, 26*(S1), 133-148. https://doi.org/10.3138/cja.26.suppl_1.133

Lai, D. W. (2008). Intention of use of long-term care facilities and home support services by Chinese-Canadian family caregivers. *Social Work in Health Care, 47*(3), 259–276. https://doi.org/10.1080/00981380801985382

Lai, D. W., & Surood, S. (2008). Service barriers of Chinese family caregivers in Canada. *Journal of Gerontological Social Work, 51*(3-4), 315-366. https://doi.org/10.1080/01634370802039650

Lai, D. W., Luk, P. K., & Andruske, C. L. (2007). Gender Differences in Caregiving: A Case in Chinese Canadian Caregivers. *Journal of Women & Aging, 19*(3-4), 161-178.

https://doi.org/10.1300/j074v19n03_11

Lai. D. W. (2004). Predicting factors for intention of use of long-term care facilities by aging Chinese-Canadians. *Journal of Social Work in Long-Term Care, 3*(2), 31-46. https://doi.org/10.1300/J181v03n02_04

Lancaster, J., & Stanhope, M. (2000). *Community & public health nursing* (5th ed.). Mosby.

Lawton, M. P., Kleban, M. Moss, M., Rovine, M., & licksman, A. (1989). Measuring caregiver appraisal. *Journal of Gerontology, 44*(3), 61-71. https://doi.org/10.1093/geronj/44.3.P61

Lee. Y., & Sung, K. (1997). Cultural differences in caregiving motivations for demented parents: Korean caregivers versus American caregivers. *The International Journal of Aging and Human Development, 44*(2),115-127. https://doi.org/10.2190/BLY5-07M1-6VVY-XJMX

Li, H. (2006). Rural older adults' access barriers to in-home and community-based services. *Social Work Research, 30*(2), 109-118. https://doi.org/10.1093/swr/30.2.109

Li, H., & Tracy, M. (1999). Family support, financial needs, and health care needs of rural elderly in China: A field study. *Journal of Cross-Cultural Gerontology, 14*(4), 357-371. https://doi-org.uml.idm.oclc.org/10.1023/A:1006607707655

Linda, S. S. (2013). Reaching for cultural competence. *Nursing, 43*(6), 37-38. https://doi.org/10.1097/01.NURSE.0000431039.75689.f2

Lindsay, C. (2001). The Chinese Community in Canada. Statistics Canada. Retrieved from: http://www.statcan.gc.ca/pub/89-621-x/89-621-x2006001-eng.pdf

Liu, L., & Tinker, A. (2003). Admission to nursing homes in Taiwan. *Social Policy and Administration, 37*(4), 376-394. https://doi.org/10.1111/1467-9515.00346

Liu. Y. L. (2003). Aging service need and use among Chinese American seniors: Intragroup variations. *Journal of Cross-Cultural Gerontology, 18*, 273-301. https://doi.org/10.1023/B:JCCG.0000004899.74875.ef

Locher, J., Bronstein, J., Robinson, C., Williams, C., & Ritchie, C. (2006). Ethical Issues Involving Research Conducted with Homebound Older Adults. *The Gerontologist, 46*(2), 160–164. https://doi.org/10.1093/geront/46.2.160

Louw, B. (2016). Cultural competence and ethical decision making for health care professionals. *Humanities and Social Science, 4*(2), 41-52. https://doi.org/10.11648.j.hss.s.2016040201.17

Lum, T., Yan, E., Ho, A., Shum, M., Wong, G., Lau, M., & Wang, J. (2016). Measuring filial piety in the 21st century: development, factor structure, and reliability of the 10-item contemporary filial piety scale. *Journal of Applied Gerontology, 35*(11), 1235–1247. https://doi.org/10.1177/0733464815570664

Ma, N. C. (2006). The practice of filial piety and its impact on long-term care policies for elderly people in Asian Chinese communities. *Asian Journal of Gerontology & Geriatrics, 1*(1), 31-35. https://doi.org/10.1177/0091415018812399

Manitoba Health, Seniors and Active Living Information Management and Analytics. (2018). Annual Statistics 2016-2017. Retrieved from: https://www.gov.mb.ca/health/annstats/as1617.pdf

Mccaskill, G., Burgio, L., Decoster, J., & Roff, L. (2011). The use of Morycz's desire-to-institutionalize scale across three racial/ethnic groups. *Journal of Aging and Health, 23*(1), 195–202. https://doi.org/10.1177/0898264310381275

Mcneese-Smith, D. (1999). A content analysis of staff nurse descriptions of job satisfaction and dissatisfaction. *Journal of Advanced Nursing, 29*(6), 1332–1341. https://doi.org/10.1046/j.1365-2648.1999.01018.x

Mitchell, B. A. (2014). Generational juggling acts in midlife families: gendered and ethnocultural intersections. *Journal of Women & Aging, 26*(4), 332-350. https://doi.org/10.1080/08952841.2014.907666

Morycz, R. (1985). Caregiving strain and the desire to institutionalize family members with Alzheimer's disease: possible predictors and model development. *Research on Aging, 7*(3), 329–361. https://doi.org/10.1177/0164027585007003002

Moule, P., Aveyard, H., & Goodman, M. (2017). *Nursing research: an introduction* (3rd ed.). SAGE Publications Ltd.

Munro, B. (2005). *Statistical methods for health care research* (5th ed.). Lippincott Williams & Wilkins

National Institute on Aging (2017). *What is Long-term Care.* https://www.nia.nih.gov/health/what-long-term-care

Order No. 24 of the President of the People's Republic of China. (2015). Law of the People's Republic of China on the Protection of the Rights and Interests of the Elderly (2015 Amendment) (Effective). http://en.pkulaw.cn/display.aspx?cgid=252608&lib=law

Patton, M. (2015). *Qualitative research & evaluation methods: integrating theory and practice* (4th ed.). Thousand Oaks, SAGE Publications, Inc.

Pharr, J. R., Francis, C. D., Terry, C., & Clark, M. C. (2014). Culture, caregiving and health: exploring the influence of culture on family caregiver experiences. *ISRN Public Health, 2014*, 1-8. http://dx.doi.org/10.1155/2014/689826

Plichta, S., Kelvin, E., & Munro, B. (2013). *Munro's statistical methods for health care research* (6th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

Plonsky, L., & Gass, S. (2011). Quantitative research methods, study quality, and outcomes: The case of interaction research. *Language Learning, 61*(2), 325–366. https://doi.org/10.1111/j.1467-9922.2011.00640.x

Polit, D., & Beck, C. (2004). Nursing Research: Principles and Methods (7th ed). Lippincott.

Polit, D.F., & Beck, C.T. (2012) *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* (9th ed.). Lippincott, Williams & Wilkins, Philadelphia.

Pynoos, J., Nishita, C., Cicero, C., & Caraviello, R. (2008). Aging in place, housing, and the law. *Elder Law Journal, 16*, 77-105.

Reinhard, S. C., Given, B., Petlick, N. H., & Bemis, A. (2008). Supporting Family Caregivers in Providing Care. In Rockville (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK2665/

Rubinstein, R. (1987). Childless elderly: Theoretical perspectives and practical concerns. *Journal of Cross-Cultural Gerontology, 2*(1). 1-14. https://doi-org.uml.idm.oclc.org/10.1007/BF00117173

Scherbring, M. (2001). Effect of caregiver perception of preparedness on burden in an oncology population. *Quality of Life Research, 10*(3), 230.

https://doi.org/10.1188/02.ONF.E70-E76

Segrin, C (2010). Multiple Regression. In Salkind. N. J. Editor, *Encyclopedia of Research Design* (845-849). SAGE Publications, Inc.

Sellers, R. (1998). *Qualitative versus Quantitative Research: Choosing the Right Approach.* The NonProfit Times, 15th March 1998.

Sethi, B., Williams, A., Zhu, H., Shen, E., & Ireson, R. (2017). Father is the Sky. Mother is the Earth: The influence of filial piety in the caregiving experiences of mandarin-speaking Chinese caregiver-employees in southern Ontario, Canada. *Diversity and Equality in Health and Care, 14*(2), 53-62. https://doi.org/10.21767/2049-5471.100093

Sims-Gould, J., Martin-Matthews, A., & Gignac, M. (2008). Episodic Crises in the Provision of Care to Elderly Relatives. *Journal of Applied Gerontology, 27*(2), 123-140. https://doi.org/0.1177/0733464807311434

Statistics Canada. (2013). *Portrait of caregivers, 2012*. Retrieved from: https://www150.statcan.gc.ca/n1/pub/89-652-x/89-652-x2013001-eng.pdf

Statistics Canada. (2015*). Family caregiving: What are the consequences?* Retrieved from: https://www150.statcan.gc.ca/n1/pub/75-006-x/2013001/article/11858-eng.htm

Statistics Canada. (2015). *Receiving care at home.* Retrieved from: https://www150.statcan.gc.ca/n1/pub/89-652-x/89-652-x2014002-eng.htm

Statistics Canada. (2017). Focus on Geography Series, 2016 Census. Statistics Canada Catalogue no. 98-404-X2016001. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=7

Statistics Canada. (2017). *Immigrant population in Canada, 2016 Census of Population*. Retrieved from: https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2017028-eng.htm

Statistics Canada. (2017). *Immigrant population in Canada, 2016 Census of Population*. Retrieved from: https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2017028-eng.htm

Statistics Canada. (2018). *Immigration and Ethnocultural Diversity in Canada*. Retrieved from: https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm

Statistics Canada. (2020). *Caregivers in Canada, 2018*. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/200108/dq200108a-eng.htm

Statistics Canada. (2020). *Support received by caregivers in Canada*. Retrieved from: https://www150.statcan.gc.ca/n1/en/pub/75-006-x/2020001/article/00001-eng.pdf?st=4JGGpN6O

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2,* 53–55. https://doi.org/10.5116/ijme.4dfb.8dfd

Teodoro, I., Reboucas, V., Thorne,S., Souza, N., Brito, Lídia., & Alencar, P. (2018). Interpretive description: a viable methodological approach for nursing research. *Escola Anna Nery, 22*(3). https://doi.org/10.1590/2177-9465-ean-2017-0287

Tew, C., Tan, L., Luo, N., Ng, W., & Yap, P. (2011). Why family caregivers choose to institutionalize a loved one with dementia: a Singapore perspective. *Dementia and Geriatric Cognitive Disorders, 30*(6), 509-516. https://doi.org/10.1159/000320260

The Conference Board of Canada. (2018). *Meeting the Care Needs of Canada's Aging Population*. Retrieved from: https://www.cma.ca/En/Lists/Medias/Conference%20Board%20of%20Canada%20-%20Meeting%20the%20Care%20Needs%20of%20Canada%27s%20Aging%20Population.PDF

The State Council (2016). *China's nursing home beds rise to 6.7m in 2015*. http://english.gov.cn/archive/statistics/2016/03/11/content_281475305465098.htm

Thorne, S., Kirkham, S., & Macdonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*(2), 169-177. https://doi.org/ 10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO

Tse, M. M. (2007). Nursing home placement: Perspectives of community-dwelling older persons. *Journal of Clinical Nursing, 16,* 911-917. https://doi.org/ 10.1111/j.1365-2702.2006.01833.x

Valer, D., Aires, M., Fengler, F., & Paskulin, L. (2015). Adaptation and validation of the Caregiver Burden Inventory for use with caregivers of elderly individuals. *Revista Latino-Americana de Enfermagem, 23*(1), 130–138. https://doi.org/10.1590/0104-1169.3357.2534

Warmenhoven, H., Hoebink, P., & Janssens, J. (2018). The Chinese postreform generation as caregivers: the caregiving intentions toward parents and parents-in-law of the one-child generation. *Journal of Family Issues, 39*(14), 3690–3712. https://doi.org/10.1177/0192513X18789208

Winnipeg Regional Health Authority (2019). *Accessing Long Term Care.* Retrieved from: http://www.wrha.mb.ca/ltc/access.php

Won, S.H., & Tae, Y. S. (2012). Nursing home placement: the process of decision making and adaptation among adult children caregivers of demented parents in Korea. *Asian Nursing Research, 6*(4), 143-151. https://doi.org/10.1016/j.anr.2012.10.005

World Health Organization (WHO). (2015). *World report on ageing and health.* Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=EAE54D6FA7D5053EA84CC02335E570B5?sequence=1

Xiong, C., Astell, A., Mihailidis, A., & Colantonio, A. (2018). Needs and preferences for technology among Chinese family caregivers of persons with dementia: A pilot study. *Journal of Rehabilitation and Assistive Technologies Engineering*, *5*, 2055668318775315. https://doi.org/10.1177/2055668318775315

Young, K., Braun, H., & Young, K. (1995). Review of The collected works of John W. Tukey: vol. VIII, multiple comparisons 1948-1983. *Journal of the Royal Statistical Society*, *158*(3), 629–628. http://search.proquest.com/docview/38822891/

Zarit, Steven H., & Whitlatch, Carol J. (1992). Institutional placement: phases of the transition. *Gerontologist, 32(*5), 665-672. https://doi.org./10.1093/geront/32.5.665

Zhan, H., Feng, X., & Luo, B. (2008). Placing elderly parents in institutions in urban China: A reinterpretation of filial piety. *Research on Aging, 30*(5), 543-571. https://doi.org/10.1177/0164027508319471

Zhang, K. (2017). *Chinese in Canada and Canadians in China: The Human Platform for Relationships between China and Canada*. The China Challenge Sino-Canadian Relations in the 21st Century (pp. 158-183). http://www.oapen.org/search?identifier=528194

Zhang, M., Chen, R., Chang, E., Simon. M.A., & Dong, X. (2015). The association between filial piety and loneliness among Chinese older adults in the greater Chicago area. *The Gerontologist, 55* (2), 225. https://doi.org/10.1093/geront/gnv560.13

Zhou, M., & Benton, G. (2017). Intra-Asian Chinese migrations: a historical overview. Contemporary Chinese diasporas (pp. 1-25). https://doi.org/10.1007/978-981-10-5595-9_1

Zimmer, Z., & Kwong, J. (2003). Family size and support of older adults in urban and rural China: Current effects and future implications. *Demography, 40*(1), 23-44. https://doi.org/10.1353/dem.2003.0010

Appendix A: Informed Consent

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452

Research Project Title: Factors that Impact Chinese Canadian Family Carers' Intention to Use Long-Term Care Facilities and Home Support Services

Principal Investigator: Asuka Liying, Qiao RN, College of Nursing, Faculty of Health Sciences,
University of Manitoba
Ph # [redacted]; umqiao2@myumanitoba.ca

Advisor: Dr. Michelle Lobchuk, College of Nursing,
Rady Faculty of Health Sciences, University of Manitoba
Telephone: (204)474-7135,
Email: michelle.lobchuk@umanitoba.ca

Sponsor: N/A

This consent form should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompany information.

What is the nature and purpose of the study?

The main purpose of this study is to investigate the impact of filial piety on Chinese Canadian family caregiving experiences and decision-making processes in relation to long-term care placement and home support services for a loved one.

What am I being asked to consent to? What is the nature of my participation in the study?

You are being asked to participate in my graduate student thesis study that involves your completion of a one-time online survey about your caregiving experiences and decision-making about long-term care and home care support for your loved one. All Chinese Canadian family carers living in Winnipeg are being invited to participate. The survey is hosted within a Qualtrics online survey account accessible only by the principal investigator and her advisor. The Qualtrics servers are located in the USA, which means that the data are subject to the US Patriots Act. I expect that it will take you about 20 to 30 minutes to complete one demographic data form and 40 questions. The demographic data form will ask questions about your age, gender, marital status, ect. The Contemporary Filial Piety Scale will ask your attitude toward filial piety, such as "are you going to arrange care for parents when they can no longer care for themselves". The Morycz's Desire-to-institutionalize Scale will ask you questions like "in the past 6 months, have you considered a nursing home, boarding home, or assisted living for care recipient?" to determine your intension to use long term care. The care giver burden inventory scale will ask you questions about burdens related to caregiving. You will answer questions like "I feel that I am missing out on life". In the end, you will be asked to answer two open-ended questions about your caregiving experience.

If you understand your role in the study and agree to participate in this study, please check the appropriate box at the end of this consent form and proceed to complete the survey on subsequent pages.

If you prefer to complete the consent form and questions in person, you can contact the principal investigator and schedule a date and location to meet and complete the questionnaire at a time and place convenient for them. In this case, the principal investigator will bring a laptop or tablet with access to the Internet to access the online survey. Liying will bring a hard copy of the consent form. You will then be asked to review the consent form and will be encouraged to ask her any questions. If you understand the study and your role in the project and consent to participate, you will sign the consent form and proceed to complete the survey on the provided computer. You will keep one signed copy and the principal investigator keep the other signed copy.

How will the information be handled during and after the study?

Your privacy is important. The information that you provide will be kept confidential. All study data will be collected through an online survey link common to all survey participants. So the data collected from many survey participants will be anonymous. Once data collection is complete, the Principal Investigator, will download the data from the online survey software account for storage on the University of Manitoba secure password protected network drive. Only the principal investigator, Liying Qiao, her advisor, Michelle Lobchuk and the statistician, Dr. Rasheda Rabbani, will have access to this raw questionnaire data. No identifying information will be intentionally collected within the questionnaires. It is not possible for anyone including the principal investigator to like data to the name and contact information of any study participants.

Although this on-line survey tool transmits your responses in an encrypted form (similar to online banking), and stores it on a highly secure password-protected off-campus server, there is always the risk (anytime the Internet is used for anything), however small, that someone would either legally access the data (e.g., law enforcement agencies) or illegally access the data (e.g., “hackers”). However, you can be assured that every feasible precaution is taken to protect the data.

The results from this study may be published and presented at scientific meetings. However, under no circumstances would your identity be revealed. Your name will not appear in any report or publication resulting from this study. Once the research is complete and a final report of the results is prepared, we will provide interested participants with a summary about how your participation helped our research. Liying will retain an Excel file containing all the names and contact information of participants who wish to receive a summary report. Your name and contact information will be collected in a separate data collector not linked to the survey answers you provide. The list of contact information will be stored on the password protected U of M network drive accessible only by Liying and her advisor, Michelle Lobchuk. This file will be deleted after the study summary reports have been sent to all interested participants in 12/19.

What are the benefits and burdens associated with participating in the study?

By taking part in the study, there are no immediate benefits or known physical risks to you for taking part in the study. However, the study findings will help researchers, health care administrators, and unit managers understand Chinese Canadian carers' attitudes, beliefs and, intentions about long-term care and social services for their older loved ones. Knowing this information will help clinicians know how to better support Chinese Canadian carers as they care for families. This project does not involve any more risk than you would experience in your every-day life.

Do I have to take part in the study?

Taking part in this study is voluntary. This means you can choose whether to take part or not. If you choose to take part, you can skip any questions that you prefer not to answer. If you choose to withdraw while in the process of completing the survey they may do so by closing the web-browser. As the data will be entered through an anonymous we-blink, so it is therefore not possible to remove your data if you choose to withdraw from the study after they completed the survey. Your choice not to take part or to withdraw from the study will not affect the care of your loved one.

Can I Get a Copy of the Results of the Study?

A summary of the results of the study will be made available to you if you would like to receive them once the study is completed. To indicate your interest in receiving a summary of the study, please following the link at the end of this survey which takes you to a separate data collector where your name and contact information will be collected. As this link is common to all survey participants, your name and contact information will not be linked to the survey research data you have provided. Names and contact information of participants will be stored separately from the research data collected on the secure University of Manitoba password protected network drive. This identifying information will only be accessible by the principal investigator and her advisor.

Who can I talk to if I have questions?

If you have any questions or concerns about the study, you can contact the researcher, Liying, Qiao and Phone # [redacted]. Email: umqiao2@myumanitoba.ca or Dr. Michelle Lobchuk at (204) 474-7135 or michelle.lobchuk@umanitoba.ca.

If you have any questions or concerns about your rights as a person taking part in a study, you can contact the University of Manitoba Human Ethics Coordinator at (204)474-7122 or humanethics@umanitoba.ca.

Statement of Consent

Your consent on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions they prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education/Nursing Ethics Review Board (ENREB). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca. We strongly suggest that you save a copy of this consent form for your records and reference.

○ I agree and would like to start the survey
○ I disagree and do not wish to participate

.
Signature by the participant who choose to complete the survey face to face____________________

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Appendix B: Written Invitation – Chinese Canadian family carers

Date: September 10, 2019

To: Chinese Canadian family carers

Fr: Asuka Liying,Qiao, Graduate Student,College of Nursing, University of Manitoba.

Advisor: Dr. Michelle Lobchuk (advisor), College of Nursing, Rady Faculty of Health Sciences, University of Manitoba Telephone: (204)474-7135, Email: Michelle.Lobchuk@umanitoba.ca

Re: Invitation to participate in the study of factors that impact Chinese Canadian family carers' intention to use long-term care facilities and home support services

This serves as an invitation for you to consider participating in the study, "Factors that impact Chinese Canadian family carers' intention to use long-term care facilities and home care support services for aging parents" that is being conducted by Liying Qiao, RN, BN, Master student of Nursing, College of Nursing, Rady Faculty of Health Sciences, University of Manitoba. This study has been approved by the Education Nursing Research Ethics board at the University of Manitoba.

Liying is doing research about Chinese Canadian family carers' caregiving experiences, attitudes toward health care services, and intention to use long term care for their loved ones. Getting an accurate picture of family carers' attitudes toward long term care will be helpful to healthcare administrators and health care professionals to offer better support for Chinese Canadian family carers who provide care to families.

Family care is defined as people aged 15 and over who responded that they had, in the previous 12 months, either provided help or care to a person with a long-term health condition or a physical or mental disability, or with problems related to aging.

This study is being conducted through an online survey. It requires that family carers complete a one-time survey that captures family carers' demographic information (e.g., age, gender, marital status, etc.) and their attitudes toward institutionalization. It will take participants approximately 20 to 30 minutes to complete the on-line survey.

Your participation is completely voluntary. If you decide not to participate, this decision will not lead to any penalty to you.

If you are interested in learning more about this study, you can contact Asuka at [redacted] [redacted] or Email: umqiao2@myumanitoba.ca.

Thank you for your time in considering your participation in this important study. The following link will take you to the survey:

https://umnursing.ca1.qualtrics.com/jfe/form/SV_0255F2wlhpDMDaZ

Appendix C: Demographic Data Collection Form

Information gathered in this form will help us get to know you better. All information will be kept confidential.
All responses will remain anonymous and are voluntary. Please do not identify your name.
Please circle numbered item that is applicable to you.

1. Age

01 18-30 years of age
02 31-40 years of age
03 41-50 years of age
04 51-60 years of age
05 > 60 years of age
06 Prefer not to identify

2. Gender

01 Male
02 Female
03 Prefer not to identify

3. Marital Status

01 Never married
02 Legally Married/Common-Law
03 Separated (but not divorced)
04 Divorced
05 Widowed
06 Prefer not to identify

4. You are the care receiver's

01 Son
02 Daughter
03 Son-in-law
04 Daughter-in-law
05 Prefer not to identify

5. How long have you been living in Canada?

01 Less than five years
02 5-10 years
03 10-15 years
04 15-20 years
05 More than 20 years
06 Prefer not to identify

6. You are living
   - 01 With the care receiver
   - 02 Not with the care receiver but live within 10km distance
   - 03 Not with the care receiver and live more than 10km distance
   - 04 Prefer not to identify

7. Education:
   - 01 Less than high school
   - 02 High school graduate
   - 03 Partial College (at least 1 yr or specialized training)
   - 04 College or University Graduate
   - 05 Graduate degree/professional training
   - 06 Prefer not to identify

8. Present employment status:
   - 01 Full time (35 hours or more a week)
   - 02 Part-time (less than 35 hours a week)
   - 03 Unemployed but available
   - 04 Home maker
   - 05 Retired
   - 06 Disabled
   - 07 Prefer not to identify

9. Annual Incomes:
   - 01 Less than $10,000
   - 02 $10,000 to less than $30,000
   - 03 $ 30,000 to less than $50,000
   - 04 $ 50,000 to less than $70,000
   - 05 $ 70,000 and above
   - 06 Prefer not to identify

10. Years of being a family care?
   - 01 Less than 5 years
   - 02 5-10 years
   - 03 11-15 years
   - 04 16-20 years
   - 05 > 20 years
   - 06 Prefer not to identify

11. Age of your care receiver?
   - 01 < 50 years How many in this category? ______
   - 02 50-60 years How many in this category? ______

03 61-70 years How many in this category? ______
04 71-80 years How many in this category? ______
05 81-90 years How many in this category? ______
06 >90 years
07 Prefer not to identify

12. Is the recipient receiving home care currently?
01 Yes
02 No
03 Prefer not to identify

13. If yes to question #12, for how long the care recipient receiving home care?
01 Less than 1 years
02 1-5 years
03 6-10 years
04 11-15 years
05 16-20 years
06 > 20 years
07 Prefer not to identify

14. Do you know anything about homecare services?
01 Yes
02 No
03 Prefer not to identify

15. If yes to question #14, can you explain what you know about home care services?

____
____
____
____

16. Do you speak any dialect other than Mandarin?
01 Yes Please identify which dialect ______________
02 No
03 Prefer not to identify

Appendix D: 10-Item Contemporary Filial Piety Scale (CFPS-10)

Used with permission

For each of the following statements, please choose the response that best corresponds to your opinion. The responses range from “not important” with the statements (1), to “very important” with the statement (5).

1) Arrange care for parents when they can no longer care for themselves
2) Provide financial subsistence to parents when they can no longer financially support themselves
3) Arrange appropriate treatment for parents when they fall ill
4) Attend parents’ funerals no matter where I am
5) Visit parents regularly if I am not living with them
6) Be thankful to parents’ nurturing
7) Try my best to achieve parents’ expectation
8) Always be polite when talking to parents
9) Try my best to complete parents’ unachieved goals
10) Always care about parents’ well-being

Appendix E: Morycz's Desire-to-Institutionalize Scale (Morycz's DTI scale)

Used with permission

For each of the following statements, please choose the response that best corresponds to your opinion. Please response the question with "yes" or "no" answers.

1. In the past 6 months, have you considered a nursing home, boarding home, or assisted living for care recipient (CR)?
2. In the past 6 months, have you felt that the CR would be better off in a nursing home, boarding home, or assisted living?
3. In the past 6 months, have you discussed the possibility of a nursing, boarding home, or assisted living with family members or others?
4. In the past 6 months, have you discussed the possibility with CR?
5. In the past 6 months, have you taken any steps toward placement?
6. In the next 6 months, are you likely to move CR to another living arrangement?

Appendix F: Care Giver Burden Inventory (CBI)

(Novak and Guest. 1989) Used with permission

For each of the following statements, please choose the response that best corresponds to your opinion. Choose the number that best represents how often the statement describes your feelings.

0 - Never
1 - Rarely
2 - Sometimes
3 - Quite Frequently
4 - Nearly Always

1, My care receiver needs my help to perform many daily tasks.
2. My care receiver is dependent on me.
3. I have to watch my care receiver constantly.
4. I have to help my care receiver with many basics Functions.
5. I don't have a minute's break from my caregiving chores.
6. I feel that I am missing out on life.
7. I wish I could escape from this situation.
8. My social life has suffered.
9. I feel emotionally drained due to caring for my care receiver.
10. I expected that things would be different at this point in my life.
11. I'm not getting enough sleep.
12. My health has suffered.
13. Caregiving has made me physically sick.
14. I'm physically tired.
15. I don't get along with other family members as well as I used to.
16. My caregiving efforts aren't appreciated by others in my family.
17. I've had problems with my marriage.
18. I don't do as good a job at work as I used to.
19. I feel resentful of other relatives who could but do not help.
20. I feel embarrassed over my care receiver's behavior.
21. I feel ashamed of my care receiver.
22. I resent my care receiver.
23. I feel uncomfortable when I have friends over.
24. I feel angry about my interactions with my care receiver

Appendix G: Open-ended Questions

1. What are some barriers that do not help you to make a decision about long-term care and use of home care services for your loved one?
2. What are some facilitators that help you to make a decision about long-term care and use of home care services for your loved one?

Appendix H: Community Service Attitude Inventory (CSAI)

1) People outside my family would think less of me if I used services.
2) My family would think less of me if I used services for my relative's care.
3) My family prevents me from using services for my relative.
4) Families should not use community services to care for a relative with disease.
5) I do not want others to know my relative has disease.
6) My family supports my use of community services
7) People from community services can take care of my relative as well as I can.
8) I am fearful of having people from community services take care of my relative.
9) I trust people from community services to take care of my relative.
10) People from community services would follow my directions in caring for my relative.
11) It is hard to trust someone from community services to care for my relative.
12) People from community services might be better at caring for my relative.
13) I worry about my relative's safety when someone else is taking care of him/her
14) Community services might have better ideas about caring for my relative.
15) I would rather use community services than ask for help from family
16) I would rather use community services than ask for help from friends
17) I would rather ask my family for help than use community services.
18) I would rather ask my friends for help than use community services.
19) I am proud of being able to care for my relative with little help from community services.
20) I believe in the idea that families should care for their own and not ask for outside help.
21) I think I should care for my relative without help from community services.
22) I feel good about using community services to help care for my relative
23) It is not the government's responsibility to help me find ways to care for my relative
24) I would use more services if the government would provide more assistance.
25) I believe the government should support more community services to help families care for persons at home.

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Appendix I: Permission to post invitation letter

Date: September 7, 2019

To: Yishizhuxing Manager,
From: Liying,Qiao, Graduate Student,College of Nursing, University of Manitoba.
Telephone: [redacted], Email: umqiao2@myumanitoba.ca

Advisor: Dr. Michelle Lobchuk (advisor), College of Nursing, Rady Faculty of Health Sciences, University of Manitoba Telephone: (204)474-7135, Email: Michelle.Lobchuk@umanitoba.ca

Re: Permission to post invitation letter about thesis study entitled, factors that impact Chinese Canadian family carers' intention to use long-term care facilities and home support services

This is in follow-up to my earlier email where I sought your permission to post an invitation letter about my study. My name is Liying Qiao (Asuka) and I am a master of nursing student at the College of Nursing, University of Manitoba.

I am once again writing to seek your permission to advertise my thesis study on your website. My project is about Chinese Canadian family carers' attitudes toward long-term care facilities and home care support services for aging parents. Study participants will be asked to respond to 40 survey questions. Please find attached my invitation letter that I will use to recruit eligible family carer participants. This study has been approved by the Education Nursing Research Ethics Board at the University of Manitoba.

With your permission I would like to post this invitation letter on your website for 2 to 3 months during my data collection period which starts in September 2019. I have the following three requests for you:(1) permission for me to post or store my invitation letter on your website; (2) your assistance in sending my invitation letter to your groups and to your members; and, (3) advise on whether I need to seek further permission from your leadership committee. If I need to seek further permission from your leadership, I am willing to do so.

If you are interested in learning more about this study, you can contact Asuka at [redacted] or Email: umqiao2@myumanitoba.ca.

If you have any questions or concerns about this study, you can contact the University of

Manitoba Human Ethics Coordinator at (204)474-7122 or humanethics@umanitoba.ca.

Sincerely,

Liying Qiao