

Motivations for upward care: Middle adolescents' relational experiences of older persons in an economically vulnerable community

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PREFACE

The candidate elected to write an article for submission to the **Journal of Intergenerational Relationships (JIR)** because the chosen research theme concurs with the aim and scope of the journal. The **Journal of Intergenerational Relationships** acts as a forum for scholars, practitioners, policy makers, educators, and advocates, who aim to remain in touch with the latest research focusing on intergenerational relationships, practice methods and policy initiatives.

JIR typically publishes papers whose content addresses intergenerational relationships evidenced in intergenerational practice, policy and research. JIR articles reflect ongoing interaction among multiple or skipped generations. Intergenerational relationships are found to occur in familial and non-familial settings and involve interaction that demonstrates positive and negative interactions. The journal was selected for publication as this research focuses on the younger generations' (adolescents) motivations to provide care in relations with the older generation (persons older than 60 years). Thus, adolescents' motivations for upward care provision were explored, in an attempt to obtain an in-depth understanding of interactions in the relationships between these generations. The findings may be applied to the development of intergenerational programmes and interventions for practice purposes, to promote well-being.

Note: For examination purposes the guidelines of this journal will not be strictly adhered to. However, upon submission of the article for publication, all the guidelines will be met.

INTENDED JOURNAL AND GUIDELINES FOR AUTHORS

This dissertation will be submitted to the *Journal of Intergenerational Relationships* for possible publication.

Instruction to Authors

Research-Based Papers

- Include relevant literature, research question(s), methodology, and results.
- Discuss implications for practice, policy, and further research in an emerging multidisciplinary field of study.
- Include conceptual, theoretical, and/or empirical content.

Manuscript Length: The manuscript may be approximately **15-20 typed pages** double-spaced (approximately **5000 words including references and abstract**). Under special conditions, a paper with 6000 words could be considered.

Manuscript Style: References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article.

Manuscript Preparation: All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract.

Cover Page: *Important* - indicating the article title plus:

- an introductory footnote with authors' academic degrees, professional titles, affiliations, mailing addresses, and any desired acknowledgment of research support or other credit.

Second "title page": Enclose an additional title page. Include the title again plus:

- an ABSTRACT not longer than 100 words. Below the abstract, provide 3-5 key words for bibliographic access, indexing, and abstracting purposes.

Preparation of Tables, Figures, and Illustrations: Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines.

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files

Tables and Figures: Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

More direct information concerning the proposed submission can be retrieved from the website.

ACKNOWLEDGEMENTS

“Groot is die Here wat ’n welbehae het in die vrede van sy kneg!” Psalm 35:27b

First and foremost, I would like to honour my Heavenly Father for all that I am and for all that He is. I have felt His presence every step of the way, and I am truly grateful for His guidance through yet another adventure.

Second, I would like to thank Prof. Vera Roos for her guidance, support and overall contribution to my work and my being. She is a phenomenal person and researcher, and I am eternally grateful to her for patiently teaching me, for transferring her excitement about research, and for believing in me.

I also want to thank Kareni Bannister sincerely for her invaluable input with regard to the language editing of my thesis.

Third, I wish to express my everlasting gratitude towards my family and especially my mom, Mrs. Tine Stols, for their support, always. Thank you for every word of motivation, for every prayer and for the love and care I experience from all of you daily.

Last, I would like to thank each individual for participating in this research, for sharing their experiences and allowing me to do the same.

“I have written you down, now you will live forever. And all the world will read you, you will live forever. In eyes not yet created on tongues that are not born. I have written you down now you will live forever.”

Bastille

DEDICATION

I wish to dedicate this study to my late grandparents, **Rev. Kosie Smit** and **Mrs Jantje Smit**, who showed me what unconditional care and support truly mean by the way they lived. Thank you for being an example to live by. You were two of the most amazing persons I ever had the privilege of knowing and I am proud to know my heritage through your lives.

OPSOMMING

'n Oorkoepelende navorsingsprojek is onderneem om die ervaringe van sorg en respek binne intergenerasionele verhoudings te ondersoek. Hierdie studie, wat deel vorm van die projek, het meer spesifiek gefokus op adolessente se motiverings om sorg te bied aan persone ouer as 60 jaar. Sorg word normaalweg uitgedruk in die interaksies tussen mense, en in hierdie geval tussen lede van verskillende generasies. In die Afrika-konteks is sorg tussen lede van verskillende generasies belangrik, want sorg word juis tussen generasies in 'n sosiale of familiële konteks gebied en nie noodwendig deur die regering of ander semi-staatsinstellings, in terme van formele sorgdienste nie. Sorg spesifiek vir die ouer persoon het 'n skaars kommoditeit geword. Weens verskeie aspekte soos die groeiende ouer bevolking, armoede, werkloosheid en HIV/VIGS het sekere strukturele veranderinge in families en tussen generasies ingetree. Die veranderinge het sorg beïnvloed deur 'n groter hoeveelheid afhanklike persone asook 'n tekort aan versorgingskapasiteit te lewer. Adolessente is belangrik in die verhouding met ouer persone, want dikwels is die verhouding tussen mense van verskillende generasies wat hulself in gedepriveerde omgewings bevind, die enigste bron vir die voorsiening van sorg. Die bevindinge van hierdie studie kan moontlik 'n aanduiding gee van hoe die sorg in verhouding tot ouer persone gemotiveer word sodat daar beter beplan word vir die sorgbehoefte van ouer persone. Die motivering om sorg te gee is veral belangrik want sommige motiveringstipes gee aanleiding tot meer volhoubare optrede en sorg as ander. Intergenerasionele ondersteuning en sorg is tans in aanvraag, wat die teenwoordigheid van minder volhoubare tipes motivering te kenne gegee. Sorg verwys in hierdie studie na die bevrediging van sosiale doelwitte en sielkundige behoeftes deur middel van tasbare (instrumentele/ fisiese sorg) en ontasbare (emosionele sorg) verruiling tussen lede van verskillende generasies. Intergenerasionele sorg sluit in opwaartse en afwaartse

sorg. Opwaartse sorg vind plaas wanneer sorg van 'n jonger generasie oorgedra word na 'n ouer persoon, terwyl afwaartse sorg verwys na sorg wat verskaf word deur ouer persone aan jonger persone. Vorige studies verwys meestal na informele sorggewing, afwaartse sorg, of opwaartse sorg deur volwasse kinders. Slegs 'n beperkte aantal studies het al die opwaartse sorg wat deur adolessente verskaf word ondersoek, veral wanneer dit kom by persone ouer as 60, en navorsing oor jonger mense se motiverings is ook baie skaars.

Die teoretiese raamwerk wat hierdie studie onderlê is die Selfdeterminasie-teorie (SDT). Hierdie teorie handel oor motivering, wat bekend is as die krag wat mense dring om op te tree of om 'n aktiwiteit soos sorg uit te voer. SDT sluit twee breë kategorieë of motiveringstipes in, naamlik outonome en beheerde motiverings. Die outonome motiveringskategorie sluit motiveringstipes soos intrinsieke motivering in (gedrag wat spruit uit die inherent bevredigende ervaring wat 'n aktiwiteit bied), saam met twee goed geïnternaliseerde ekstrasiekie motiveringstipes (naamlik identifikasie en geïntegreerde regulering). Beheerde motivering sluit ook twee meer beheerde en minder geïnternaliseerde ekstrasiekie motiveringstipes in (naamlik eksterne en geïntrojekteerde regulasie). Ekstrasiekie motivering is die uitvoer van 'n aktiwiteit vir 'n aparte en eksterne uitkoms. Die verskillende tipes motivering inkorporeer gevolglik verskillende vlakke van selfbeskikking en selfkeuse om sekere aktiwiteite te doen. 'n Meer outonome (selfbeskikkende) motiveringstipe gee aanleiding tot meer volhoubare optrede.

Adolessente het kragtens hulle ego en kognitiewe ontwikkeling die vermoë om meer outonoom en intrinsiek gemotiveerd te wees. Selfs al het hulle die vermoë om meer outonoom gemotiveerd te wees, is dit nie altyd die geval nie. Persone in hierdie fase van psigo-sosiale ontwikkeling volgens Erikson se lewensloopbenadering, fokus meer op eweknieverhoudinge en neig om te konformeer aan gemeenskapsverwagting en sosiale groepnorme. In sulke gevalle kan

adolessente motiverings ervaar wat minder outonome motiveringstipes insluit omdat hulle beheer word deur eksterne verwagting en norme. Ongelukkig kan minder outonome motiveringstipes aanleiding gee tot minder volhoubare optredes.

'n Kwalitatiewe navorsingsmetode is gebruik om adolessente se ervarings van sorg in verhoudings met ouer persone te beskryf. In die bevindinge was die motivering vir die sorg 'n hooftema, en vandaar die besluit om slegs op hierdie aspek te fokus in hierdie studie. Die deelnemers het 15 Setswana-sprekende adolessente (sewe seuns en agt meisies) tussen die ouderdomme van 12 en 16 ingesluit wat gekies is op grond van 'n nie-waarskynlikheid gerieflikheidsteekproefneming. Data is ingesamel in die ekonomies weerlose gemeenskap waar die deelnemers woonagtig is, naamlik die Vaalharts landbouvallei in die Noord-Kaapprovinsie van Suid-Afrika. Die gemeenskap word as ekonomies weerloos beskou omdat die meerderheid van die lede van die gemeenskap slegs ongereelde inkomste verdien en steun op karige regeringstoelae om multi-generasie huishoudings te onderhou.

15 deelnemers is ingesluit in die navorsing en agt individue het ook deelgeneem in die Mmogo-metode®, 'n projektiewe visuele data-insamelingsmetode, en al 15 deelnemers het self-reflektiewe joernaalinskrywings gemaak om die data aan te vul. Gedurende die Mmogo-metode® sessie word deelnemers gevra om iets te bou wat sal wys hoe hulle sorg in verhouding tot 'n persoon ouer as 60 ervaar deur 'n bol klei, grasspriet en krale te gebruik. Die selfreflektiewe navorsingsjoernale het semigestruktureerde vrae ingesluit om die deelnemers te lei. Beskrywende fenomenologies psigologiese, tematiese en visuele analise is toegepas om die versamelde data in te samel.

Geloofwaardigheid, betroubaarheid, oordraagbaarheid en navolgbaarheid is toegepas om seker te maak van die betroubaarheid van die studie. Etiese navorsingsoptrede is verseker

deurdat die riglyne van die Departement van Gesondheid rakende etiese navorsingsoptrede in Suid-Afrika, sowel as die raamwerk wat verskaf word in Hoofstuk 9 van die Wet op Gesondheid 61 van 2003 nagevolg is. Eerstens het 'n waargenome afwesigheid van ouer persone in intergenerationele sorg verhoudings vanuit die bevindinge na vore gekom.

Bevindinge toon verder dat die jonger generasie deur eksterne stimuli gedryf is om fisiese/instrumentele versorging te bied, soos bv. dat hulle die ouer persoon sien sukkel of uit gehoorsaamheid aan die ouer persoon se eksplisiete versoeke vir hulp voldoen. Weens die eksterne stimuli is adolessente ekstrinsiek gemotiveer om sorg te gee deur gehoorsaamheid en perspektief-neming. Die deelnemers is ook ekstrinsiek gemotiveer deur gevoelens van verpligting; om ouer persone se geluk te verseker; weens hul posisie van ondergeskiktheid aan ouer persone; asook om sorg wat van ouer persone ontvang is, terug te bied. Alhoewel die deelnemers ekstrinsiek gemotiveer word om te sorg, was daar verskillende vlakke van selfbeskikking en selfkeuse teenwoordig in hulle optrede. Hierdie bevinding bied 'n breër bewustheid rakende adolessente se motiverings om sorg te bied. Die kennis wat versamel is as deel van hierdie projek kan intergenerasionele programme wat ontwerp is om gevoelens van outonomie te fasiliteer en wat dankbaarheid as 'n motiveerder in intergenerasionele en interpersoonlike omgewings benadruk, onderbou.

Sleutelwoorde: Ekonomies weerlose gemeenskap; Intergenerasionele verhoudings; Middel adolessensie; Motivering; Selfdeterminasie-teorie; Sorg..

SUMMARY

A broader research project was undertaken on experiences of care and respect within intergenerational relationships. The current study, which forms part of this project, focused more specifically on adolescents' motivations for providing care to persons older than 60 years. Care is normally expressed in the interactions between people, and in this instance between generational members. In the African context, care between generational members is important because care is particularly provided in a social and familial context between generations and not necessarily by the government in terms of formal care services. Care, specifically for older persons has become a scarce commodity. In the light of different aspects like the growing older population, poverty, unemployment, and HIV/AIDS certain structural changes in families and between generations have come about. The changes influenced caregiving by delivering a larger number of dependant persons and a lack of capacity to provide care. Adolescents are important in the relationship with older persons, because often the relationship between persons from different generations, who find themselves in a deprived environment, is the only source for the provision of care. The findings of this study can possibly give an indication of how care in relation to older persons are being motivated in order to better plan for the care needs of older persons. The motivation for demonstrating care is particularly important because some motivation types are perceived to encourage more sustainable actions and caregiving than others. Currently intergenerational support and care are in short supply, suggesting the presence of less sustainable types of motivation.

Care, in this study, refers to the satisfaction of social goals and psychological needs by means of tangible (instrumental/physical care) and intangible (emotional care) exchanges between intergenerational members. Intergenerational care encompasses upward and downward

care. Upward care occurs when care is transferred from a younger generation to older persons, while downward care refers to care provided by older persons to younger people. Previous studies referred mostly to informal caregiving, downward care, or upward care provided by adult children. A limited number of studies exist of upward care provided by adolescents, specifically to persons older than 60, and research on younger people's motivations for care is also rare.

The theoretical framework that informs this study is Self-Determination Theory (SDT). This theory revolves around motivation, known as the force that compels one to act, or to conduct an activity such as care. SDT includes two broad categories of motivation types, namely autonomous and controlled motivations. The autonomous (self-determined) motivation category includes intrinsic motivation (i.e. conduct that stems from the inherently satisfying experience a particular activity offers), along with two well-internalized extrinsic motivation subtypes (namely identification and integrated regulation). Controlled motivation includes two more controlled and less internalized motivation subtypes (namely external and introjected regulation). Extrinsic motivation is when an activity is performed for a separate and external outcome. The different types of motivation consequently incorporate differing levels of self-determination to conduct certain activities. The more autonomous (self-determined) the motivation, the more sustainable actions of care.

Adolescents are capable in terms of ego and cognitive development to be more self-determined and intrinsically motivated. Even though they may have the capacity to be more self-determined motivated, this is not always the case. Persons at this stage of psychosocial development according to Erikson's lifespan approach focus more on peer relationships, and tend to conform to community expectations and social group norms. In such cases adolescents may experience motivations that include less self-determined motivation types, because they are

controlled by external expectations and norms. Unfortunately less self-determined motivation types may also produce less sustainable care actions.

A qualitative research method was applied to describe adolescents' experiences of care in relation to older persons. In the findings, motivation for care was a major theme and it was therefore decided to focus only on this aspect in this study. The participants included 15 Setswana-speaking adolescents (seven boys and eight girls) between the ages of 12 and 16, who were selected by means of a nonprobability convenience sampling method. Data were collected in an economically vulnerable community where the participants lived, Vaalharts agricultural valley in the Northern Cape Province of South Africa. This community is considered economically vulnerable because the majority of its members receive only irregular income and have to rely on meagre government grants to support multi-generational households.

15 Participants were included in the research; eight individuals participated in the Mmogo-method®, a projective visual data-gathering method, and all 15 participants completed self-reflective journal entries to supplement the data. During the Mmogo-method® session, participants were asked to build something that would show how they experienced care in relation to a person older than 60, using a lump of clay, grass stalks and beads. The self-reflective research journals included semi-structured questions to guide the participants. Descriptive phenomenological psychological, thematic, and visual analysis was employed to analyse the collected data.

Credibility, dependability, transferability and conformability were applied to ensure the trustworthiness of the study. Moreover, ethical research conduct was ensured by applying the guidelines provided by the Department of Health for responsible and ethical research conduct in South Africa as well as the framework provided in Chapter 9 of the National Health Act 61 of

2003. Firstly a perceived absence of older persons in caring relationships emerged from the findings. The findings further revealed that the younger generation was moved by external stimuli such as observing struggling older persons or by obeying older persons' explicit requests for help, to provide physical/instrumental care to older persons. In response to external stimuli adolescents were extrinsically motivated to care which was observed in obedience and perspective taking. The participants were also extrinsically motivated by feelings of obligation; to ensure older persons' happiness; from their submissive position in relation to older persons; and for returning care that were bestowed on them by the older persons. However, although the participants were extrinsically motivated to care, different levels of self-determination and self-choice seemed to be present in their behaviour. These findings provide a broader awareness with regard to adolescents' motivations for care provision. The knowledge gained from this project could serve to inform intergenerational programmes designed to facilitate feelings of autonomy and emphasize gratitude as a motivator in intergenerational and interpersonal environments.

Keywords: Care; Economically vulnerable community; Intergenerational relationships; Middle Adolescence; Motivation; Self-determination theory.

PERMISSION TO SUBMIT ARTICLE FOR EXAMINATION PURPOSES

The candidate chose to write an article, with the support of her supervisor. I hereby grant permission that Miss Anneke Stols may submit this article for examination purposes in partial fulfilment of the requirements for the degree: Master of Arts in Research Psychology.

Prof. V. Roos

DECLARATION BY RESEARCHER

I, **Ms. Anneke Stols**, hereby declare that the dissertation **Motivations for upward care: Middle adolescents' relational experiences of older persons in an economically vulnerable community** is my own work I also declare that I have not plagiarized another persons' work, and that all sources that I consulted have been referenced and acknowledged.

Furthermore I declare that a qualified language editor has edited this dissertation, as was proposed by the North-West University. Lastly I declare that this research was submitted to Turn-it-in and an acceptable report was received stating that plagiarism had not been committed.

Ms Anneke Stols

DECLARATION BY THE LANGUAGE EDITOR

I hereby declare that I have language edited the thesis **Motivations for upward care: Middle adolescents' relational experiences of older persons in an economically vulnerable community** by Anneke Stols for the degree of MA in Research Psychology.

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LITERATURE REVIEW AND BACKGROUND

This research study falls within the ambit of a broader research project addressing care and respect between members of different generations living in a South African economically vulnerable community. The current study focuses specifically on adolescents (12-16 years of age) and their motivations for providing care to older persons in the context of their relational experiences with persons older than 60. The inquiry on the experiences of care, for the purpose of this research does not distinguish between actual experience and the intentions to care for older persons. The inquiry was used to elicit descriptions of behaviour that could indicate types of motivation. Thus for the purpose of this research the focus was not on intentions. It could have been that intentions were revealed in the data but for this purpose it is not significant, because it is assumed that intentions underline behaviour ((e.g. theory of planned behaviour), Ajzen, 1991; 2002). But based on the verbal discourse of these participants, it is very difficult to delineate what is regarded as intentions and what is regarded as actual experiences. Therefore, the focus of this study was mainly to present descriptions of motivations for care in the care provision for older persons. Accordingly, a relational definition of care will inform this study; care (tangible or intangible) is the bartered outcome of needs or goals within intergenerational relationships.

Research on intergenerational care for older persons, generation one (G1), by younger persons, generation three (G3), in economically deprived environments is becoming increasingly important. This is due to certain structural changes that have taken place within intergenerational and family relationships, which have caused these relationships to be less predictable and that may undesirably affect filial commitment and caregiving. These structural changes resulted from the occurrence of lower fertility rates, divorce in families, working

caregiver households and older persons' extended need for caregiving because of their decreasing mortality rate (Biggs & Lowenstein, 2011; Silverstein & Giarrusso, 2010; VanderVen, 2004). However, as a result of the increasing older growing population nationally and internationally (Aboderin, 2006; Aboderin, 2012; Newman & Hatton-Yeo, 2008; Roos & Malan, 2012; Strom & Strom, 2014; Whyte, Alber, & Van der Geest, 2008) as well as the prevalence of HIV/AIDS and poverty (Hoffman, 2014; Keating, 2011), there is a growing dependency on family or community members (especially those who are part of the younger generation) to provide care for older persons in African and other developing societies (Aboderin, 2006; Brandt, Haberkern, & Szydluk, 2009; VanderVen, 2004; Wisensale, 2003).

Intergenerational care is challenged, however, by a disconnect in the relationships between generations (Bengston & Oyama, 2007; Bohman, van Wyk, & Ekman, 2008; Cumming-Potvin & Maccallum, 2010; Mabaso, 2011; Makiwane, 2010; Newman & Hatton-Yeo, 2008). Research indicates that different generations concentrate more on age-segregated communication (Strom & Strom, 2014). Bohman et al. (2008), Mabaso (2011), Makiwane (2010) and Roos (2011) emphasized a disconnect between aged persons and late adolescents or young adults in the South African context. Accordingly this level of disconnection raises some concern over the ultimate care for older persons (Bohman et al., 2008; Strom & Strom, 2014), and the durability of the younger generation's motivation to provide care. Younger persons' motivation for providing care to older persons might yield insights into what steps should be taken to ensure the younger generation remains sufficiently motivated to provide care for the older generations.

To address the aim of this study a literature review follows, in which care is described in relation to different theoretical constructs. First, care will be defined and a distinction will be made between the different types of care. Next, intergenerational relations are defined and care

in these relationships is described. Following this, a description of the reciprocal nature of intergenerational care in economically deprived communities is provided. Upward care and some of the motives for it will be discussed in international as well as national contexts. The theoretical framework of the self-determination theory will be described to provide a better understanding of motivation for care actions. Giving and receiving of care are included across the lifespan, following Erikson's psychosocial stages of development.

The Theory of Care

Care is defined as a set of actions or activities a person practises to adapt, preserve, and mend the world to enable an optimal life for oneself and others (Green & Lawson, 2011; Tronto, 2001). The complex and multidimensional concept of care is further unpacked into four phases; "caring about", "caring for" (Glenn, 2000; Van der Vyver, 2011), "caregiving", and "care receiving" (Tronto, 2001; 2010). "Caring about" includes the awareness and consideration of another's needs, and thus forms a morality or virtue element of the care practice. "Caring for" refers to undertaking the responsibility of satisfying or addressing another person's care needs. "Caregiving" engages the specific provision of activities that are executed in order to meet the needs of other persons, hence forming the action element of the care practice. The final phase, "care receiving" is when the response of the person who received care is evaluated to determine if his or her care needs have been satisfied (Tronto, 2001; 2010). According to Glenn (2000) the action element of care consists of three care activities, namely bathing and feeding a person (i.e. "physical care"); encouraging someone and responsive listening (i.e. "emotional care"); and providing assistance with errands or accompanying someone on visits to the doctor (i.e. "direct services").

Silverstein et al. (2013) describes care in three categories, namely instrumental care (i.e. assistance with household tasks such as laundry and other housework, or assistance with “personal care”; dressing, bathing, feeding, and nursing activities); economic care (i.e. financial support), as well as emotional care (i.e. receiving emotional care or debating important decisions relating to someone’s life). These categories of Silverstein et al. (2013) correspond to Glenn’s (2000) “physical care”, and “emotional care” care activity components. Evidently, from the above discussion, care can either be tangible (instrumental care, direct services, physical, practical, and economic care) (Antonucci, Birditt, Sherman, & Trinh, 2011) and/or intangible (“concern, dedication, and attachment” or “to act with special devotion” (Van der Geest, 2002, p. 7)). Sung (2004) identified another form of care, namely care-respect, highlighting the link between care and respect in the provision of care and services to older people in intergenerational relationships. Care-respect refers to providing care in a respectful manner (Sung, 2004). The importance of intergenerational relations as a resource to address the instrumental and emotional care needs of older people has been realized by many (Aboderin, 2006; Bohman et al., 2008; Møller, 1998; Schwartz, Trommsdorff, Albert, & Mayer, 2005; Wisensale, 2003; Xu & Chi, 2011). It is thus important to conceptualize care in intergenerational relationships.

Care and Intergenerational Relations

Much research has been conducted to explore and identify the relational experiences between the different generations from different perspectives. The research was undertaken in order to promote solidarity between generations by introducing intergenerational programmes which, in some cases, suggest a degree of care exchanges between generations (Bengston &

Oyama, 2007; Cumming-Potvin & Maccallum, 2010; Elli & Granvill, 1999; Krzyzowski, 2011; Larkin, 2004; Møller, 1998; Oduaran & Oduaran, 2004; Roos, 2011).

A generation is often referred to as a group of people from the same age group, with common characteristics occurring across the specific group (Rogler, 2002). Generations are classified into three categories: the three-generation lineage includes older persons (older than 60 years) or the first generation (G1), the second generation, which is people who are currently adults (G2) and adolescents (or the youth) as the third generation (G3) (Bengston, 1975; Bailey, Hill, Oesterle, & Hawkins, 2009). The relationships between members of distinct generations are termed intergenerational relationships (Braungart, 1984; Scabini & Marta, 2006). Various types of intergenerational relationships exist; social generations refer to a group of people who have been influenced by specific historical events they have experienced and who are not familially related (Scabini & Marta, 2006). Familial intergenerational relationships are relations which involve persons from different generations who were born from the same blood lineage (Whyte et al., 2008). Non-familial intergenerational relationships or social intergenerational relationships refer to relationships between different generations who are not related to one another, such as family friends, fellow church members, teachers and students, neighbours, and so forth (Hurd, Varner, & Rowley, 2012; Zimmerman, Bingenheimer, & Behrendt, 2005). In the South African context, younger persons (from G3) are often raised by non-familial community members or older persons. Older persons in the same community are commonly considered family even though they are not part of the younger persons' family lineage (Bohman et al., 2008; Roos, 2011). The younger persons are increasingly dependent on these older persons (G1) to assist them and provide for their care needs, due to parents' migration to the cities and effects of the HIV/AIDS pandemic (Aboderin, 2012; Eke, 2003; Hoffman, 2004, Hoffman, 2014;

Makiwane, 2010; Oduaran, 2006). Often younger persons are expected to assist older persons with regard to their care needs (Hoffman, 2014). Hanks (as cited in Hanks & Ponzetti, 2004) indicated that persons in non-familial relations may also experience special caregiving obligations (usually associated with familial caregiving) towards other generations. Thus, care may also be reciprocally exchanged between socially related generations (Constanzo & Hoy, 2007). Therefore in this research, both familially and socially related intergenerational relations will be included.

The Reciprocal Nature of Intergenerational Care in Economically Vulnerable Communities

Reciprocity refers to giving and receiving of care between members of different generations, informed by the nature of the interpersonal contact (Aboderin, 2006; Roos, in press; Van der Geest, 2002). A constant theme of reciprocity in human relations emerges from international studies regarding care (i.e., Bohman et al., 2008; Brandt et al., 2009; Knodel & Chayovan, 2009; Makiwane, 2010; Schwartz, et al. 2005; Van der Geest, 2002; Xu & Chi, 2011). In a study on care between different generations, Van der Geest's (2002) notion of the reciprocity of care is also noteworthy. In economically vulnerable areas older persons are often reliant on this reciprocal process to receive care (Brandt et al., 2009; Van der Geest, 2002; Xu & Chi, 2011). Care in these deprived areas takes place between related generations, because fewer resources are provided by other agencies like governmental bodies, to help with the provision of care (Brandt et al., 2009; Haberkern & Szydlik, 2010; Knodel & Chayovan, 2009). Due to limited resources provided by government, the family members are called on to reciprocate care (Bohman et al., 2008; Brandt et al., 2009; Knodel & Chayovan, 2009). However, in South Africa support is provided by the state in the form of a modest old age pension, which is in most

cases the main source of income for economically vulnerable, multigenerational households (Bohman et al., 2008; Hoffman, 2003; Makiwane, 2010). Furthermore, it was found (in the South African context) that because older persons are under pressure due to limited resources at their disposal, the younger generations' level of social support may be declining fast (Eke, 2003, Hoffman, 2014). "Times of limited resources induce a cost/contribution balance between the generations" (Bengston & Oyama, 2007, p. 11), and unfortunately the exchange of care on an economic as well as social level, does not thrive where resources are limited (Eke, 2003). Hence the reciprocal co-dependence among generations is found to be a form of subsidizing care. The reason for this subsidy includes factors such as HIV/AIDS, poverty, unemployment, changes in living arrangements and the struggle to meet reciprocal care expectations. These factors have taken their toll on families and especially the younger generations (Bengston & Oyama, 2007; Eke, 2003). Not only do the younger generations now have very little to give in the reciprocal exchange relationship (Eke, 2003), but the occurrence of opportunities for intergenerational transfers of emotional and practical care are affected (Bengston & Oyama, 2007). Thus the flow of resources to the older generation declines (Bengston & Oyama, 2007; Eke, 2003; Hoffman, 2014). Consequently, if the younger generations receive only very limited care themselves and are not able to meet the older generation's proposed care expectations, they may not be particularly motivated to satisfy the emotional and instrumental care needs of the older persons.

The background provided by international studies on reciprocal care relations between generations in economically vulnerable areas informs a relational definition of care: care is the negotiated outcome of needs or goals in an intergenerational relationship. This definition focuses on recipients who are givers and receivers of care as well as on the providers of care who are also givers and receivers (Bengston & Oyama, 2007). It encompasses the exchange of the

tangible and intangible between individuals (Hoffman, 2014). People receive in the act of giving, although the needs and goals for individual participants may differ, as do their motivation and attitude in their roles as givers or receivers (Schwartz et al., 2005). The definition includes negotiation for care because people move and countermove to fulfil their needs or to obtain their goals (Molm, Schaefer, & Collet, 2007).

(Upward) Care in a Broader International Context

Upward care, provided in return for downward care received, forms part of the reciprocity process in the intergenerational care exchange (Molm et al., 2007). Care which is provided to older persons (G1 as care receivers) by their children or grandchildren (G2 or G3 as caregivers) is termed upward care (Lee & Bauer, 2013; Lin & Wu, 2014). Similarly, downward care can be understood as the care provision by grandparents (G1 as caregivers) to or for their children (G2) or grandchildren (G3) (Lee & Bauer, 2013; Lin & Wu, 2014). Some studies in various contexts, focused especially on grandparents as caregivers for grandchildren, have been undertaken (Ardington et al., 2010; Goh, 2009; Igel & Szydluk, 2011; Michels, Albert, & Ferring, 2011; Knodel & Chayovan, 2009; Musil et al., 2010; Oduaran, 2006; Roos, 2011; Silverstein, 2007; Van der Geest, 2002; Weber & Waldrop, 2000; Zimmer & Dayton, 2005). Likewise, studies of older persons' motivations for downward care were also conducted (Lee & Bauer, 2013). However, for the purpose of this research, an in-depth discussion will concentrate on upward care, which forms the focus of this study. The reason for this focus is that older persons in a South African context are often, and for an extended period of time, reliant on adolescent family members for upward care (Aboderin, 2006; Brandt et al., 2009; Silverstein & Giarrusso, 2010; VanderVen, 2004; Wisensale, 2003).

In different countries upward care presents in various forms and is provided by different parties for a variety of reasons. Intergenerational upward care in Europe is mostly provided by adult children if funds for private care are inadequate (Szydlik, 2012). In Northern European countries, these children provide instrumental care, seen as help, when they have time to do so (Brandt et al., 2009; Haberkern & Szydlik, 2010). The necessary immediate care, which results from the older generation's needs, is usually provided by government services (Brandt et al., 2009). If professional government services provide a degree of care, it is more likely that children will be motivated to help their parents and assist in household tasks, thus providing a degree of personal care (Brandt et al., 2009; Haberkern & Szydlik, 2010). Due to less readily available professional services and support, families (who sometimes feel under pressure) in Southern European countries, as well as Austria, the Benelux countries and Switzerland, mostly provide practical intergenerational care (Brandt et al., 2009; Haberkern & Szydlik, 2010; Szydlik, 2012). Consequently, adult children from Northern Europe are motivated by affection to provide care. In contrast family carers in the Southern European countries are rather motivated by feelings of obligation (Brand et al., 2009; Szydlik, 2012). In a Norwegian context, younger adults are likely to provide for older persons' overall care needs in the form of practical and financial support because they feel a filial responsibility as well as genuine concern (Daatland, Veenstra, & Herlofson, 2012).

In Thailand, care forms part of the daily family support older persons receives from adult children. However, grandchildren also have a role to play in providing care by completing household tasks (i.e. direct services), and accompanying the older persons (a form of emotional care) (Knodel & Chayovan, 2009). The adult children are, according to Knodel and Chayovan (2009), moved to provide care by a moral obligation to return care and to show gratitude. The

care and support they provide are also a means of reciprocal repayment. Grandchildren in rural China are expected to care for their grandparents when they are grown up, and currently assist their grandparents with household tasks, and emotional as well as practical daily care (Xu & Chi, 2011). The support and care provided may be motivated by cultural principles such as filial piety and family harmony (Xu & Chi, 2011). Giles, Dailey, Sarkar, and Makoni (2007) found that young adult grandchildren provide care-respect and emotional care to the older people in India because of religious obligations.

In a Ghanaian study, care was found to be provided to members of the older generation by one of their adult children, or grandchildren. They focused on practical care, while emotional care emerged only occasionally (Van der Geest, 2002). The continuing care provision by these children is often driven by an obligation, or devotion, to give back the care they received from the older persons as parents (Van der Geest, 2002). A study in Southern as well as Eastern Africa (Evans & Atim, 2011) produced findings that physical care is provided to parents who are living with HIV/AIDS by their children, who sometimes also felt a sense of obligation to return care. In a South African context, older persons who live in multigenerational households are cared for by adult children and in some cases by their grandchildren (Bohman et al., 2008; Hoffman, 2014). This upward care takes the form of help with household tasks or grandchildren giving attention to the older persons. In this study (Bohman et al., 2008) the adult children express their motivation as reciprocity. Bohman et al. (2008) also found that other generations expect grandchildren to be motivated to care by a feeling of obligation to repay their grandparents or to show respect. To receive and provide any type of care is a distinctive psychological need of human existence and directly related to the concept of motivation (Haivas, Hofmans, & Pepermans, 2013; Ryan & Deci, 2000b).

Theoretical Framework: Self-Determination Theory

The term motivation reflects the willpower that moves a person, to think, to act, or to advance, or in the case of this study, to provide care (Deci & Ryan, 2008a). The Self-Determination Theory (SDT) (Deci & Ryan, 1985) describes human motivations, especially in relation to various issues such as distinctive psychological needs, life ambitions, personality development and regulation, cultural relation to motivation, etc. (Deci & Ryan, 2008b). SDT argues that all individuals attempt to satisfy essential psychological needs. These include a need to feel related to another and to be autonomous and competent (Deci & Ryan, 2008a; Deci & Ryan, 2008b; Ryan & Deci, 2000a). The need for relatedness refers to an individual's longing to feel connected to and cared for by significant others. It also includes providing care for another and experiencing a feeling of belonging (Baumeister & Leary, 1995; Ryan & Deci, 2000b; Vansteenkiste et al., 2007). Autonomy refers to "the feeling of volition that can accompany any act, whether dependent or independent" (Ryan & Deci, 2000a, p.74), or to act out of personal willingness (Ryan & Deci, 2000a). Competence refers to the need to feel that one possesses the necessary ability to succeed in acquiring the desired outcome for a set goal, and to be efficient in meeting a goal's requirements (Ryan & Deci, 2000b; Vansteenkiste et al., 2007). The degree to which people satisfy these needs contributes to the internalization of behaviour which informs the strength as well as the type of motivations that are present (Deci & Ryan, 2008a; 2008b). The more internalized the motivation, the more self-determined or autonomous the behaviour of a person. In such a case actions are informed by a sense of choice and present as being less controlled (Deci & Ryan, 2008b; Ryan & Deci, 2000a). In this regard, behaviour is likely into the category of an autonomous motivation. In contrast, when people's behaviour regulations are

less internalized, their motivation falls within a controlled motivation category (Deci & Ryan, 2008a).

Deci and Ryan's (1985) SDT concentrates on the types and the quantity of motivation that result in certain performance outcomes, or actions (Deci & Ryan, 2008b). Actions are observable in caring behaviour and activities (Baumeister & Leary, 1995; England, Folbre, & Leana, 2012; Lyonette & Yardley, 2003). According to SDT, different factors motivate people to act in a caring manner or to perform an activity such as care. People may be driven by the internal value they associate with a care activity or they may be moved by an external force (Ryan & Deci, 2000a). Consequentially, different types of motivation may be identified in caring behaviour, namely intrinsic motivation and extrinsic motivation (England et al., 2012; Lyonette & Yardley, 2003).

Intrinsic motivation is a self-determined motivation and refers to performing an action or activity for the inherent fulfilment people experience from the activity itself or to satisfy their curiosity (Deci & Ryan, 2008b; Ryan & Deci, 2000a). Intrinsic motivation for spontaneous caring behaviours, for instance, can be enhanced by events that strengthen feelings of capability, relatedness and/or independence. However, individuals will only be intrinsically motivated to take part in events or complete deeds they find inherently appealing or challenging. In other words, individuals will participate in the events and deeds that hold intrinsic interest or the possibility of personal growth for them (Ryan & Deci, 2000a). Care is intrinsically motivated when it provides a fulfilling experience or when behaviour is driven by an inner value (caring norm) that is connected to the activity (Deci & Ryan 2008a; England et al., 2012). From the discussion it follows that intrinsic motivation is not linked to influential or instrumental motives,

such as rewards or approval (Ryan & Deci, 2000a). This type of motivation is an autonomous motivation type (Deci & Ryan, 2008a).

As mentioned above, the different types of motivation reflect varying degrees of internalization and integration of behaviour (Ryan & Deci, 2000a). Internalization is also known as the degree to which the value and regulation of (care) behaviour have been absorbed. The level to which the behaviour has been integrated (the level of integration) means that people have transformed or adopted the behaviour as their own and this spontaneously informs their behaviour in future (Ryan & Deci, 2000a). When care behaviours and values do not emerge spontaneously but are instead precipitated externally, people's motivation may be described as extrinsic. Extrinsic motivation means that people perform caring activities because they are result-driven, or demonstrate caring behaviour because they will achieve an expected outcome (Ryan & Deci, 2000b), for example, when people provide care to others and their behaviour or actions of reciprocating care form the care goal they want to achieve (England et al., 2012).

Four types of extrinsic motivation are identified in SDT, and vary in the rate of autonomy (self-determination) that is present during the performance of activities. Two types of extrinsic motivation are included in the controlled motivations category, and the other two types in the autonomous motivations category (Deci & Ryan, 2008a; Ryan & Deci, 2000a).

External regulation is the first controlled type of extrinsic motivation and is the least autonomous. It includes extrinsically motivated actions which are performed to reach certain positive outcomes or rewards, or to avoid negative outcomes or punishment (Ryan & Deci, 2000a). For example, in a caring relationships, the relationship will consist of care actions in order to achieve an instrumental reward (Ryan & Deci, 2000a; 2000b), such as monetary payment (Deci & Ryan, 2008a), or to avoid punishment by meeting certain expected

requirements (Haivas, Hofmans, & Pepermans, 2013). Other examples of reward include achieving a desired status (e.g. association with a certain social group), or reducing the likelihood of being nagged or scolded to provide care (Patrick, 2014). These actions or behaviours are thus caused by factors outside the self, and are often interpersonally controlled (Ryan & Deci, 2000b).

The other form of controlled motivation involves internalizing a regulation, but not fully accepting and integrating it as part of the self (Deci & Ryan, 2008a). Introjected regulated actions are thus still externally caused (Deci & Ryan, 2008; Ryan & Deci, 2000a). With regard to care relations, introjected regulation involves an obligation to perform certain activities (like providing care). The success of such an activity will influence the care provider's self-esteem (MacIntyre & Potter, 2014; Patrick, 2014; Sheldon et al., 2004; Stone, Deci, & Ryan, 2009). Identification regulation occurs when a person's care behaviour is internalized because it holds personal importance for that person (Ryan & Deci, 2000a). An example of identification regulation is seen when the care behaviour is relevant to developing a prosperous relationship (Patrick, 2014). Accordingly, this type of regulation is perceived as more self-determined and autonomous than introjected regulation (Deci & Ryan, 2008a).

The final and most autonomous or self-determined type of extrinsic motivation is known as integrated regulation. This occurs when behaviour have been, through self-examination, fully evaluated, absorbed and integrated into a person's values and needs (Ryan & Deci, 2000a; 2000b). In a caring relationship, people motivated by integrated regulation can be identified when care behaviours accord with a person's broader familial and social connections (Patrick, 2014).

The more motives for actions are internalized and integrated to the self, the more autonomous and self-determined extrinsically motivated actions become (Ryan & Deci, 2000b). Intrinsic motivation and integrated regulated motivation are similar in their autonomous character, although the nature of their proposed outcomes differs (Deci & Ryan, 2008a). Therefore integrated regulation is still grouped under extrinsic motivation, because these actions are executed to attain an outcome which holds instrumental value and not for the inherent fulfilment accompanying the actions (Ryan & Deci, 2000a; 2000b). Nonetheless, together with regulation through identification and intrinsically motivated behaviour, integrated regulation completes the autonomous motivation compound.

A person's intention to act or execute care behaviour is reflected in controlled as well as autonomous motivation. However, the quality of the outcome (of caring behaviour) is not reflected in these types of motivation (Deci & Ryan, 2008a; Ryan & Deci, 2000a). People's capacity to be intrinsically motivated and their ability to care differ according to their level of development (Ryan & Deci, 2000a; 2008b).

Care and Erikson's Psycho-Social Stages of Development

Care in intergenerational relations is understood from a lifespan approach and specifically the psychosocial stages of development described by Erikson (1982). Depending on a person's development stage, certain individuals will be more prone to provide care, while others will be more likely to receive care. During the first stage of Erikson's model the helpless infant (aged 0-1 year) counts on the caregiver for all his or her needs (Sigelman & Rider, 2009). A reciprocal process of bonding and caring emerges between the baby and adult (Graves & Larkin, 2006). For the duration of the following childhood stages, children grow from dependency to autonomy, and eventually they leave home (Graves & Larkin, 2006). Children in

these stages are mostly dependant on their parents (especially the mother) both for emotional and physical care (Sigelman & Rider, 2009). Erikson (1950) found that the autonomy versus shame and doubt stage (aged 1-3 years) becomes very important in forming the development of self-control and willpower with regard to the love-hate, and cooperation-wilfulness ratio in life. During the initiative versus guilt phase (aged 3-6 years), children become increasingly aware of their own and other's emotions. They develop skills and knowledge to react appropriately both to adults' and their peer groups' emotions. The skills they develop empower them to show emotional care, especially towards their peers (Louw & Louw, 2007). Industry versus inferiority (aged 6-12 years) precedes the adolescent stage, and it is during this phase that children become increasingly less dependent on their parents for support with regard to daily decisions (Louw & Louw, 2007). They also learn how to function socially beyond the family context, building relationships with other children (including those of the opposite gender) and expanding their social environment to school (Erikson, 1963; Weiten, 2010). Children's relationships with peers are based on affection, friendship and companionship (emotional care), while siblings become an important source of support. Parents may also be an important source of support, but the child-parent relationship is based more on the child's need to receive care and protection (Louw & Louw, 2007). Since early childhood, children are taught behaviours that are acceptable by parents and siblings, which may lead to a decrease in intrinsically motivated behaviour (Louw & Louw, 2007; Ryan & Deci, 2000a).

The start of the adolescent phase of development coincides with the onset of pubertal maturation, and is believed currently to occur at earlier ages (9-12 years) than in previous years (Crone & Dahl, 2012). Thus the duration of the adolescent phase varies and is considered by some to include young people aged from 10-20 years (Wigfield, Byrnes, & Eccles, 2006), 11-21

years (Bowden & Smith Greenberg, 2010), 12-20 years (Sigelman & Rider, 2009), and 13-19 years (Erikson, 1963). Adolescents are believed to focus especially on the establishment of their identity and future roles (Erikson, 1963; Sigelman & Rider, 2009). The focus of social interaction shifts from the family to socialization with peer-groups (Louw & Louw, 2007; Nurmi, 2004). This interaction contributes to satisfaction of emotional needs. In this relational context it is very probable that care and help are provided within these peer relationships, although the young people are still cared for by parents and family members (Louw & Louw, 2007). Adolescents may also experience reduced freedom to be intrinsically motivated. A possible reason for this is that during adolescence individuals tend to conform to social group norms and community expectations (Bjorklund & Hernandez Blasi, 2012). It is specifically at this stage of adolescence that certain social or community expectations and responsibilities, which fall outside a person's field of interests, may develop (Ryan & Deci, 2000a). Conversely, behaviour can become more integrated to a person's values and more intrinsically motivated as ego and cognitive capabilities develop (Ryan & Deci, 2000a; 2000b). Hence adolescents may have the ability and inclination to be more intrinsically motivated, depending on the development of the individual, because an individual's regulatory style tends to become more internal as he or she moves towards autonomy and self-determination over time (Ryan & Deci, 2000b).

In the next stage of intimacy versus isolation (20 to 40 years), individuals often enter marriages and parenthood, when the ability of emotional care as well as instrumental care is implemented in the family, including the spouse and children (Weiten, 2010). This is also a stage at which support and care are provided to parents or friends, and received from their spouses (Marks, 1996; Cavanaugh & Blanchard-Fields, 2014). During the generativity versus stagnation stage (persons aged 40-65 years), the older adults start to develop a sense of concern

and care for the younger generations' well-being. The older adults want to feel that they leave a legacy behind in the form of the future generation (Cheng, 2009), thus not stagnating in the past, but looking forward (Bradley, 1997). Sometimes people in this stage also have to care for their elderly parents (Marks, 1996). In the late adulthood stage (65 years and older) people's ability to care physically for themselves and others decreases and they will become increasingly dependent on family members for caregiving (Marks, 1996). Close friendships are an important source of emotional care throughout adulthood (Arnett, 2007; Cavanaugh & Blanchard-Fields, 2014), but it is at the late adulthood stage that the closest social relationships (with either partners, siblings, closest children or friends) become older adults' main source of emotional and instrumental care (Cavanaugh & Blanchard-Fields, 2014; Fingerman & Pitzer, 2007; Walen & Lachman, 2000). However, in this stage care provision for grandchildren and spouses may also occur (Bengston & Oyama, 2007; Cavanaugh & Blanchard-Fields, 2014; Marks, 1996).

Article Proceedings

Following the above literature review the findings of this research will be recorded and discussed in the form of an article, which will be submitted for publication. The aim of the article is to explore adolescents' motivations for upward care in relations with persons older than 60 years. The findings could be used in community intervention programmes to support individuals from different generations to overcome the perceived disconnection in relationships between them. Finally, a critical reflection will emphasize how this study may inform and affect current literature regarding intergenerational relations.

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MANUSCRIPT FOR EXAMINATION

Motivations for upward care: Middle adolescents' relational experiences of older persons in an economically vulnerable community

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Abstract

Care is an essential aspect of human life and even more important in the light of the phenomenon of population ageing. It can take the form of physical/instrumental (tangible) and/or emotional (intangible) care, and can also be provided downwardly or upwardly. Care actions can be extrinsically or intrinsically motivated. Motivation for the purpose of this study is theoretically informed by the Self-Determination Theory. Intergenerational care research with regard to upward care motivations focuses mostly on care provided by adult children and not on adolescents in a community context. This study aims to investigate what motivates adolescents to care for persons older than 60. The sample studied consisted of 15 Setswana-speaking adolescents (aged 12-16 years) living in Vaalharts, an economically vulnerable community in South Africa. Data-gathering techniques included the Mmogo-method® and journal entries. Textual and visual data were obtained and analysed using descriptive phenomenological psychological-, thematic-, and visual analysis. Findings revealed an initial perceived absence of older persons as either the providers or recipients in care relations. Middle adolescents' motivation for upward care was externally provoked by external stimuli. In response to the external stimuli, adolescents physically and emotionally cared for older people. They were motivated by obedience and perspective-taking as well as feelings of obligation. Consequently, adolescents were moved into action by a combination of extrinsic motivation and internalised external motivators with varying levels of self-determination. A better understanding of what motivates autonomous caring behaviour will be able to inform intergenerational programmes.

Keywords: Care; Economically vulnerable community; Intergenerational relationships; Middle adolescence; Motivation; Self-determination theory.

Introduction

This study focuses specifically on motivations of care for older persons from the perspective of adolescents. This study is part of a broader research project conducted on intergenerational care and respect in an economically vulnerable community in South Africa. The different themes that emerged from the data were the types and manifestations of care provided in an intergenerational relationship as well as adolescents' motivations for care in these relationships. The types and manifestations of care will be discussed by De Jager (2014).

Care and Intergenerational Relations

Care is always expressed in a relational context (Muraco & Fredriksen-Goldsen, 2011), and it is inherent within intergenerational relationships (Brandt, Haberkern, & Szydlik, 2009; Haberkern & Szydlik, 2010; Knodel & Chayovan, 2009). Intergenerational relationships may be defined as relationships between different generations (groups of people from a similar age group and sharing common characteristics) who are either familially or socially related (Braungart, 1984; Rogler, 2002; Scabini & Marta, 2006). In some South African communities, there is no distinction drawn between socially- and familially-related relationships (Chilisa, 2012). Intergenerational relationships are important in caregiving because of the needs of the growing older population and because of the negative effects of HIV/AIDS (Aboderin, 2006; Eke, 2003; Hoffman, 2014; United Nations [UN], 2013). These relationships are even more important in an economically vulnerable context, in which there is a greater reliance on family or community members for care (Aboderin, 2006; Brandt et al., 2009; Haberkern & Szydlik, 2010; Knodel & Chayovan, 2009; Wisensale, 2003). An arbitrary classification of three-generation categories of intergenerational relations is proposed, where older persons are classified as the

first generation (G1), the adults comprise the second generation (G2), and the third generation (G3) includes the adolescents (Bengston, 1975; Bailey, Hill, Oesterle, & Hawkins, 2009).

The Theory of Care

Care may be defined broadly as behaviour practised in order to amend, preserve, and prolong the known social world so that optimal living for all persons may be ensured (Green & Lawson, 2011; Tronto, 2001). Various researchers view care as consisting of multiple elements, (Glenn, 2000; Mentzakis, Ryan, & McNamee, 2011; Silverstein et al., 2013; Tronto, 2001, Tronto, 2010; Van der Geest, 2002; Van der Vyver, 2011). Tronto (2001; 2010) differentiate between a virtue element of care (caring about), an element where one assumes responsibility for care work (caring for), a practical element of care (caregiving), and a response element of care (care receiving). The practical element of care (caregiving) encompasses intangible care (emotional care known as support and active listening), and tangible care (instrumental care known as conducting household tasks, and physical care activities, as well as direct services which is providing assistance with errands and appointments) (Antonucci, Birditt, Sherman, & Trinh, 2011, Glenn, 2000; Mentzakis et al., 2011; Merz, Schulze, & Schuengel, 2010; Silverstein et al., 2013; Tronto, 2001, Tronto, 2010; Van der Geest, 2002). Focusing more on the relational and reciprocal nature of care (Hoffman, 2014; Van der Geest, 2002), those who find themselves in an intergenerational relationship will at some point, although not necessarily concurrently, occupy both a care provider role and care receiver role in order to exchange tangible and intangible care (Tronto, 1993). Care provided by G1 individuals to younger generations (G2-3) is termed downward care, while upward care involves individuals from G2-3 providing care for older persons (Lee & Bauer, 2013; Lin & Wu, 2014). For the purpose of this study, care is defined as the satisfaction of needs and goals within an intergenerational relationship by means

of diverse exchanges between members of different generations. The motivation of care in intergenerational relations can be defined as that which wills a person to act, behave or care (Csikszentmihalyi, Graef, & McManama Gianinno, 2014; Deci & Ryan, 2008a).

Care and the Self-determination Theory

Care behaviours can be intrinsically or extrinsically motivated (England, Folbre, & Leana, 2012; Lyonette & Yardley, 2003). These types of motivation are distinguished in terms of different levels of autonomy (self-determination) and personal value, according to the Self-Determination Theory (SDT) (Deci & Ryan, 1985; 2008b). People are intrinsically motivated to care when care behaviour is completely self-determined, when they are motivated to care or driven by self-satisfaction and the inherent appeal of the activity (Ryan & Deci, 2000a; England et al., 2012). A person is extrinsically motivated to care when an external force facilitates the care activity or when the activity is result-driven (Ryan & Deci, 2000b). Extrinsic motivation may be subdivided into four subtypes with escalating levels of self-determination, namely 1) external (least self-determined), 2) introjected, 3) identification, and 4) integrated regulation (which is the most self-determined of the extrinsic motivation type) (Ryan & Deci, 2000a; 2000b). These extrinsically motivated subtypes not only differ in their level of self-determination, but also in the degree to which care behaviours have been internalized. However, all these subtypes are implemented to achieve an external outcome with instrumental value (Ryan & Deci, 2000a; 2000b). It is important to note that even when behaviour becomes more internalized, it does not necessarily mean that extrinsic regulated behaviour transforms into intrinsic motivation (Ryan & Deci, 2000b). The determining factors of the type of motivation are: the level of self-determination and the value of the outcome of the behaviour. The outcome

of the behaviour is determined in terms of a personal, inherent reward or external rewards (Deci & Ryan, 2008a; Ryan & Deci, 2000a).

The Relevance of the Current Study

Most intergenerational upward care studies include care provided by adult children (Aboderin, 2006; Bohman, van Wyk, & Ryan, 2008; Brandt et al., 2009; Eke, 2003; Evans & Atim, 2011; Giles, Dailey, Sarkar, & Makoni, 2007; Haberkern & Szydlik, 2010; Knodel & Chayovan, 2009; Szydlik, 2012; Van der Geest, 2002). Studies that concentrate on the relationships between G1 individuals and G3 individuals are limited, especially research from an adolescent's point of view (Attar-Schwartz, Tan, & Buchanan, 2009; Froh, Bono, & Emmons, 2010; Roos, 2011). Most studies in Africa on care in intergenerational relationships tend to associate care with adult children (Aboderin, 2006; Burman, 1996; Van der Geest, 2002). Care, in this study, may be exchanged between generations in a community that is socially connected regardless of whether they are in a genealogical kinship lineage or not (Hanks & Ponzetti, 2004). This is even more true in economically deprived areas, where the responsibility of care for the elders often rest upon the family members (or in the current study also the community members who are regarded as family), while limited help is received from government services (Brandt et al., 2009; Knodel & Chayovan, 2009).

This research will focus particularly on middle adolescents. Young people in this developmental phase are particularly relevant, because previous research on intergenerational relations between older people and children in the middle adolescent developmental phase concluded that the relationship between them was spontaneous and accepted by both generations (Nathan, 2012; Roos, in press). Relationships between older persons and young adults were found by Mabaso (2011), Mabunda (2011), Møller and Sotshongaye (2002), as well as Van

Dongen (2008) to be strained; their research indicated escalating patterns of controlling actions and growing pessimism. It was however unclear what it was that happens in the adolescent stage to bring about the change in the relationships, thus provoking the shift from spontaneous to strained. Often the relationships between the generations are the only source which provides in the care needs of older persons, thus emphasising the imperative nature of adolescent's motivation for this care provision.

Previous European and African studies show that adolescents (G3) were motivated to provide upward care to older persons (G1) because they felt a filial obligation or a devotion to show gratitude or to repay received care (reciprocal repayment) (Daatland, Veenstra, & Herlofson, 2012; Knodel & Chayovan, 2009; Van der Geest, 2002). According to Deci and Ryan (2000a) adolescents develop ego and cognitive capabilities with age, which are likely to result in an increase of intrinsically motivated behaviour. At the same time they have to adhere to certain social or community expectations and responsibilities which fall outside their control or fields of interest. Consequently, younger persons may experience a decrease in intrinsic motivation (Deci & Ryan, 2000a). So that the motivation for upward care within intergenerational relationships from the perspective of adolescents may be better understood, the following research question will guide this study: *What motivates middle adolescents to care for older persons who live in an economically vulnerable area?*

Goal of the Study

In light of the already strained relationships between older persons and young adults who are socially related in a community, this study focuses on exploring the upward motivation of care in adolescents. The purpose of the study is thus to explore middle adolescents' (aged 12 to 16 years) motivations for providing care in relationships with older people (aged 60 years and

older) to whom they are socially or familially related. A better understanding of what motivates adolescents to care could serve as a starting point for various generations to better understand the differences in alternative age-perspectives. The findings can also be used for the development of interventions to better plan for the future care needs for older persons.

Research Methodology

Research Method and Design

An explorative, descriptive approach will inform this study. Accordingly, a qualitative research method will be used in order to gain an in-depth understanding of the participants' subjective experiences of care in the specific context (Ivankova, Creswell, & Clark, 2010). Qualitative research is used when studying individuals in their natural environment with the intention of explaining and describing the quality and texture of the studied individual's experiences (Willig, 2013). Since phenomenology is concerned with an individual's manner of interpreting his or her experiences (Clissett, 2008), a phenomenological design will be employed. Furthermore, the emphasis of this design falls on describing the subjective meaning of and motives for "care" by "individuals from the younger generation" (Creswell, 2012). A deeper understanding of the phenomenon will be gained through this subjective description of the participants' experiences and way of thinking (Chilisa, 2012).

Research Context and Participants

This research study was conducted in the Vaalharts agricultural valley in the Northern Cape Province of South Africa. The younger participants mostly live in Valspan and Ganspan, neighbouring areas in the centre of the Vaalharts valley. Setswana is the predominant mother tongue in these communities, but all participants could speak English. Living arrangements in this region are poor and overcrowded, with the result that there is an 85.4% need for more and

larger housing. Oftentimes more than one family shares a one/two-room house (Coetzee, 2011). The rate of poverty in this community is very high, because most of the people are seasonal workers on farms, earning an inconsistent income and having to rely on grants. 70.2% of the residents need to apply for social (government) grants (Coetzee, 2011). The older persons' sole income consists for the most part of a small pension they receive from the government, which is also used to support multi-generational households in terms of housing, food, and other care activities. These care activities mostly related to care for grandchildren, which stresses a need to inaugurate caretaking facilities for younger and older persons (Coetzee, 2011).

Most of the younger participants attend school in Jan Kempdorp and are literate, in contrast to many members of the older generation. The school which the participants attend in Jan Kempdorp is approximately 2km from the areas where they live. Walking and taxis are the main modes of transport.

A nonprobability, convenience sampling method was used for the selection of participants from the Vaalharts valley. 15 adolescents (seven boys and eight girls) between the ages of 12 and 16 formed part of the entire study. This age classification assigns participants to the younger generation category. The inclusion criteria were that the younger people had to be living in the Vaalharts area, be aged between 12 and 16 years, and have experienced intergenerational relationships with a person older than 60 years.

Procedure and Data Gathering

The study was part of the Africa Unit for Transdisciplinary Health Research (AUTHeR) WIN Project which combined 13 sub-projects from the different health science disciplines at the North-West University (NWU). The emphasis is on building intersectoral partnerships to

improve rural health and well-being (as a whole) in this economically deprived Vaalharts area.

The psychology department was therefore also approached to take part in the WIN project.

Access to the community was obtained with the help of a WIN-project mediator from AUTHeR, who had previously established relations within the community. With the help of the mediator the research event was advertised in Vaalharts to invite individuals to take part in the research. The invitation was also announced at the school during assembly. The mediator contacted the interested volunteers, and a detailed information letter as well as informed consent forms was sent to the interested participants' parents with the help of the mediator and teachers. All parents were allowed to contact the mediator or the researcher if any questions arose with regard to the research. The complimentary transport and venue arrangements for the research were communicated to participants. Only those participants whose parents had provided permission and informed consent were allowed to join in the research project. The participants were welcomed, introduced to the research team, and every detail of the research, which was also included in the informed consent of the parents (the procedure, expectations, risk and benefits, ethical considerations, purpose, and publication possibilities), was clearly explained. Participants were reminded of the fact that taking part in the research was completely voluntary, and of their right of withdrawal without any negative consequences of prejudice.

They were again informed, verbally and by means of written consent letters, that the researchers and fieldworkers would treat the data confidentially, and that the data would be anonymized by means of coding. The participants' rights to withdraw from the research without consequence at any time were also emphasized. The participants were verbally informed and made aware that group participation meant that only partial anonymity and confidentiality would be possible within the Mmogo-method® session. They were encouraged, however, to treat

shared information as confidential. The consent process was conducted in English (which the participants could understand), but Setswana translators were present in case of confusion to ensure that participants made an informed decision. After the participants had been informed, signed consent was obtained from voluntary participants by fieldworkers who were master's students in Psychology and had undergone training by means of role-playing sessions the day before. A local venue, a big hall which accommodated the research team and the participants, was used for data collection. Different rooms were available where two Mmogo-method®-sessions were held separately. One session focused on care and included eight participants, while the other included seven participants and focused on respect. The privacy of the participants was protected as the research was conducted away from onlookers; the value of respect for all humans was thus incorporated into the research process.

Data-gathering methods consisted of the Mmogo-method® (Roos, 2008), and self-reflective journals.

Mmogo-method®. Visual data-gathering methods are frequently used to gain insight into abstract or culturally-implicit experiences such as the motivation for care for older persons (Roos, 2012; Roos, in press). The Mmogo-method® (a visual projective data-collection method) maintains that the visual presentations people create show something about each participant, as well as the social contexts of functioning (Roos, 2008). Only eight of the 15 participants participated in the Mmogo-method® data gathering session focusing on care (three boys and five girls) (Roos, 2008; Roos, 2012). Every participant was provided with a circular piece of cloth, a lump of clay, coloured beads, and grass straws (the Mmogo-method® materials) (Roos, 2012). The participants were asked to do the following: *“Please make us something that we can see, by using the clay, the straws, and the beads, about how you experience care in relation to a older*

person; somebody is older than sixty years.” The question was purposefully asked in a non-specific, broad, open-ended manner in order to allow the adolescents to focus on giving or receiving care. This question referred to experiences of care and did not distinguish between care intentions and actual care experiences. The specific question was utilized to elicit depictions of behaviour that could reveal types of motivation. Intentions are assumed to underline behaviour and strongly relate to motivations (Ajzen, 1991; 2002). Therefore intentions could have been revealed in the data, but for the purpose of this study was not significant. Experiences however can affect a person’s motivation to conduct certain actions (Dörnyei & Ushioda, 2013). Based on the discourse of participants in this study, it is an intricate matter to clearly portray what is considered to be intentions and what is considered to be actual experiences. Therefore, the purpose of this study was to present descriptions of motivations for care in the care provision for older persons. The age of 60 years and older was specified and used for an all-inclusive view of the older generation, because according to the Older Person’s Act 13 of 2006 (women) as well as the Social Assistance Amendment Act 6 of 2008 (men), any person older than 60 years, is known as an older person (senior citizens).

After the instructions had been given, the participants completed their visual presentations within approximately 45 minutes. Questions were asked about the visual representations, such as: *“What did you make? Why did you make these presentations when asked to specifically make something of care in relations with people older than 60? How would you like to receive care and how do you care for older persons or the people you made? Why do you perform that care activity?”*

After each participant had explained his or her own visual illustrations, all the participants joined in a group discussion which elaborated their views. All discussions were

audio recorded and transcribed verbatim. Photos were taken of the presentations on completion of the constructions only after consent for this had been granted by the participants. The photos provided the visual data of this study. After data collection, the participants were thanked for taking part and were provided with refreshments

Journals. The entire group of 15 participants completed journals. The purpose was to supplement data (Skinner, 2007), and to gain a deep understanding of their experiences of care. The semi-structured questions that were included in the journals are provided in table 1.

Table 1

Semi-structured questions included in the journals

-
1. What is your definition of care?
 2. Describe an incident where you felt cared for and name the persons involved.
 3. Describe an incident where you didn't feel cared for and name the persons involved.
 4. Describe an occasion where you showed care and name the persons involved.
-

The researchers asked participants to write down their opinions and experiences in relation to the above questions and return the journals to the teachers or local clinic after a few days for collection by the mediator. Participants were informed that returning the journals was not obligatory, but voluntary. Journal entries were analysed to identify recurrent themes. The evaluation of the data was submitted for supervision and peer-review.

Data Analyses

The collected data were analysed and arranged into themes utilising the following procedures:

Descriptive phenomenological psychological method. The analysis followed the steps proposed by Giorgi (2012). First, a thorough understanding of the transcribed data as a whole was acquired. Every transition in meaning that was noticed in the textual data was indicated. Then the raw data were “rewritten” by the researcher into phrases which closely resembles the words of the participants, but more clearly revealed the psychological value of what the participants had said. The transformed phrases were then revised and the essential structure of the adolescents’ experiences was written up. Finally, the essential structure was thematically analysed to assist in the clarification and interpretation of the raw data (Giorgi, 2012).

Thematic Analysis. The following steps of thematic analysis, as proposed by Braun and Clarke (2006) as well as Clarke and Braun (2013) were followed. First, the researcher again familiarized herself with the data. (Familiarization with the data was initially advanced by verbatim interview transcriptions of the Mmogo-method session, transcribed by the researcher). The transcribed data, the data in the journals, and the essential structures from the previous analysis were reviewed several times, and initial ideas were noted. Second, initial codes were generated so that the analyst was able to systematically code significant characteristics of the entire data set. The third step entailed searching for themes by sorting all relevant codes from the previous phase into their applicable groups. Next, themes or keynotes were reviewed and a thematic map of the analysis was generated. The themes were then defined and named. In this phase, the specifics of each theme were refined, so that clear names and definitions were could be formulated. Lastly, a report was written to explain findings with examples found within the data (Braun & Clarke, 2006).

Visual analysis. Visual data were derived from photos taken of the visual presentations during the Mmogo-method® data collection session (Roos, 2008; 2012) and were analysed in

accordance with each participant's explanation of his or her complete visual presentation. It was also evaluated according to the image's "relevance to the research question, and its relationship to symbolic and cultural material" (Roos, 2012, p. 253).

Trustworthiness

Trustworthiness may be used to demonstrate and evaluate the validity of a qualitative study, as well as to warrant the findings' quality (Krefting, 1991). To ensure the rigour and trustworthiness of a qualitative study, Guba's model of trustworthiness (1981) was employed (Krefting, 1991; Shenton, 2004). Four aspects are included in this model: credibility, transferability, dependability and conformability (Krefting, 1991; Shenton, 2004).

Credibility. In this research study credibility was enhanced by applying principles of crystallization (Tobin & Begley, 2004), a strategy that combines different and numerous data sources and perspectives in order to provide more depth in the understanding of the findings (Ellingson, 2009; Tracy, 2010). Therefore, as indicated by Maree and Van der Westhuizen (2010) as well as Goduka (2012), the use of a variety of data collection- and data analyzing methods assisted in the validation of the data. The variety of data collection methods used included the Mmogo-method® focus group, and participants' journals. Data analysis methods that were applied are descriptive phenomenological psychological-, thematic-, and visual analysis. The different methods provided a way of accomplishing substance through the accumulation of a variety details as well as the processing of these details (Ellingson, 2009).

Another form of crystallization was ensured was by using multiple researchers for conducting research (Kelly, 2006). In this study, a team of 12 researchers assisted in the data-collection process. Credibility was further demonstrated through strategies such as peer debriefing as well as persistent observations (Lincoln, 1995; Tracy, 2010). After every

collection session, group discussions about the data took place with all members of the research team. Observations were also recorded in writing as well as by tape recorders throughout the course of the collection process.

Peer examinations also took place; throughout the course of the research process discussions were held with researchers who were knowledgeable about care, intergenerational relations and qualitative methodology impartial to the research project. In addition the project was supervised by researchers with extensive experience in qualitative research, thus endorsing the authority of the results (Tracy, 2010).

Transferability. Transferability is seen by Krefting (1991) and Shenton (2004) as the degree to which the data can be universalized from the sample to the population. The researcher's dense and thorough description of the research context and methodology was a way in which the boundaries of the study were communicated, improving the transferability of the process (Krefting, 1991, Shenton, 2004; Tracy, 2010).

Dependability. Dependability refers to the stability of the data in determining if the findings would remain the same if the research was repeated within the same context, as well as with identical participants, and methodology (Shenton, 2004). In order to improve the dependability of the study, the particulars of the data-gathering procedure were systematically and comprehensively documented by the researcher, and the effectiveness of the process of investigation was evaluated by the researcher in a critical reflection (Shenton, 2004).

Furthermore, different researchers independently co-coded the data and reached consensus on the findings. Peer reviewing was consistently applied throughout the research process and contributed to the dependability of the research (Krefting, 1991) as well. The researcher coded

and recoded the data several times at intervals of two weeks between the analyses, whereafter results were compared (Krefting, 1991).

Confirmability. Confirmability refers to the objectivity of the data (Krefting, 1991) and was ensured by the abovementioned strategy of crystallization, where substance or depth was achieved, and more than one data-gathering method was applied (Ellingson, 2009; Shenton, 2004). A form of confirmability was established, because it proved that the findings had not been fabricated by the researcher (Tobin & Begley, 2004). The raw data were co-coded and recoded by researchers independently thus also contributing to the conformability of the research (Krefting, 1991; Shenton, 2004).

Ethical Considerations

This research project was approved (reference NWU-00053-10-S1) by the Health Research Ethics Committee of the North West University, which is registered with the National Health Research Ethics Council of South Africa. The researcher adhered to the guidelines and framework stated in Chapter 9 of the National Health Act 61 of 2003 as well as the guidelines provided by the Department of Health (2014) for conducting responsible and ethical research in South Africa.

Moreover, to the best of the researcher's understanding a favourable risk-benefit ratio existed. The direct benefits for participants included refreshments provided at the data collection venue, positive social interaction with peers in a controlled environment, and exposure to new experiences. Indirect benefits for participants and the broader research community included new knowledge about the motivations for intergenerational care which could inform the development of intergenerational programmes. As a result, cohesion within these relationships could be promoted and sustained future care for older persons within the South African context could be

inspired. Psychological harm was the only possible risk foreseen, because talking about one's experiences may provoke emotional turmoil. For this reason, a psychologist was available if debriefing was desired. Participants were also encouraged to approach the research team at any time with concerns or if they were upset or disturbed by the research process.

All collected data are protected from public access by being stored in locked cabinets in a secure location in the Department of Psychology, NWU, on the Potchefstroom campus. Digital data are stored on password-protected computers. All data will be archived for at least five years; thereafter the destruction of the data will be the responsibility of the project's primary researcher.

Findings

Four themes emerged from the data about motivations for upward care and are shown in the table below:

Table 2.

Findings: Themes and Subthemes

Themes	Subthemes
Perceived absence of older persons in caring relations	
Eliciting stimuli motivate upward care	External stimuli
	Requests of older persons
	Observing older persons struggling
Motivation as a result of external stimuli	Obedience
	Perspective taking
Obligation	To ensure older persons' happiness and satisfaction
	Middle adolescents in position of submissiveness
	Fulfilling a reciprocal contract

Perceived Absence of Older persons in Caring Relations

In this research the focus was on exploring the experience of care by adolescents in relation to older persons. It would have been expected that older persons somehow would figure

in the descriptions of care experiences, either upwardly or downwardly. However, in the first subtheme older persons were omitted as either the recipients or providers of care.

The younger persons did not focus specifically on older persons in relation to care. Fewer than half the younger people referred to them in visual representations and the self-reflective journals.

It was only after being prompted the participants mentioned their relationships with older persons. “I also love older people ...” (Participant 4).

The participants, however, spontaneously explained care in relation to peers, siblings, and other adults. “Here I made brother and sister, because I love brother and sister.” (Participant 2).



Figure 1: Two of the six visual demonstrations of care in relations with siblings (Participants 4 and 5).

The relationships with their parents and peers were described as loving, reliable, and caring relationships, which provided the assurance that their needs would be met (visually presented in Figure 1).

In these care relationships some of the participants also experienced the freedom to ask for help and the certainty that they would receive what they asked for.

“I made my brother... like my cousins. Here I like my cousins very much because they do everything for me and I do anything for them...” Sometimes “..., when I need them to help [me] with my homework, I also tell them: ‘I have my homework and this and this’. [Then] they will also help me” (Participant 4).

Eliciting Stimuli Motivated Upward Care

The external stimuli that motivated adolescents to perform care activities included specific requests from older persons and adolescents’ observations of struggling older persons.

External stimuli. External stimuli included requests from older persons and adolescents’ observations.

Requests of older persons. Middle adolescents described requests from older persons as instructions to perform certain actions. A participant expressed a request of an older person as follows: “When she’s saying: Do this, do this – I do anything...” (Participant 2), or when they are told to perform certain tasks “you help them when they tell you go to buy something” (Participant 3).

Observing older persons struggling. Middle adolescents were moved into action by observing older persons struggling with physically challenging tasks. “Maybe ...an old woman is going to a clinic and he’ll [she’ll] walk slowly, I’ll maybe help him” (Participant 4). The younger generation also noticed that older persons sometimes struggle to carry heavy objects: “Maybe he carried something that’s hard for him, [then] always I [will] help him to carry it ...” (Participant 4).

The youngsters are also motivated to take action when they observe that older persons do not know how to take care of the personal hygiene: “When they don’t know to, how to wash, I will wash them” (Participant 1), or when they are no longer able to take care of their personal

hygiene: “I showed care to my aunt. I washed her back, because she was [not] able to wash herself” (Journal Participant 10).

Extrinsic Motivation of Care as a Result of External Stimuli

The motivation for care actions were demonstrated in obedience and perspective taking.

Obedience. Middle adolescents were motivated to obey which is illustrated in Participants 2 and 3’s quotes in response to requests of older persons: “I do anything” or “I will help them”.

Perspective taking. Perspective taking was illustrated in adolescents who took the perspective of older persons and who acted accordingly to the care needs that they observed. For example, they said that when they are walking in public “[and] see some old lady walking *on the street ... suffering form that hard thing. [Then] I [will] also help him*” (Participant 4).

Obligation

Obligation refers to feeling compelled or morally bound to provide care (Aboderin, 2006). Middle adolescents were motivated by obligation in terms of obeying older persons wishes in order to make them happy, and because the older persons are their seniors; as well as to fulfil a reciprocal caring contract.

To ensure older persons’ happiness and satisfaction. The participants were motivated into action to ensure older persons’ happiness. “When someone... like, older persons, you must greet for them and then... they will be happy” (Participant 3). This responsibility they felt for the older person’s happiness were expressed when asked how they will show older persons that they love them. The participants realized that if they spent time with older persons, they (the older people) would be happy because they would not be alone: “...When he’s alone, you will be here

and he will be happy because you are here, and he is not alone” (Participant 1). Even though spending time with older persons seemed to be self-determined; the outcomes of the actions was external because they want to ensure that older persons are not alone and ultimately to ensure older persons’ happiness. The outcomes of their actions were thus motivated by an external reward and not by an inherent, personal value.

The adolescents also felt obligated to ensure the happiness of older persons, which they related to acquiring an education. The younger participants linked attending school with the happiness of the older persons: “They [older persons] are going to feel happy because I am going to school” (Participant 7). The rest of the participants confirmed this statement: “Yes, we are attending school every day properly” (Participant 4). Education would also be used to secure employment (and allow the younger people to care for older persons). “Because they (older persons) want their children when they grow up must know how to read, they must not be unemployed” (Participant 8).

Acquiring an education is externally motivated by the response of older persons, but it is also self-determined because of the personal value it holds for the younger people. “When they (the younger generation) get in school they (the older generation) are happy because their children will become a person when they grow up. [He/She] will become a person” (Participant 3), and “Something in the world” (Participant 8).

Middle adolescents in position of submissiveness. Middle adolescents were motivated to care for older persons because they are their elders: “I help ... suffering old people, yes I help him because I am a child” (Participant 6), and “They are older to us” (Participant 2; Participant 3). One participant expressed her felt obligation to obey the older persons, because of this position: “When someone is older than me I must when he send me somewhere I must go.”

(Participant 1) When adolescents were asked why they obeyed and helped the older persons, they linked care with respect: “Because I respect them.”(Participant 5; Participant 7) and “[Care] mean[s] to respect someone who is older than you even the young kids...”(Journal Participant 1). From this position of submissiveness they would comply, even if it means that they are not happy, as illustrated in the following dialogue:

- [Researcher]:* Okay, but if your grandparents tell you now, something that you don't want to do, it's really you don't want to do this. How will you show them that you don't want to do this?
- [Participant 5]:* I'm just going to shut up.
- [Researcher]:* You're just going to shut up and then say nothing? And will you then do what they ask you to do if you really don't want to do it?
- [Participant 5]:* Yes, but I won't feel happy
- [Researcher]:* You won't feel happy?
- [Participant 6]:* I'll do it because I'll show the respect to them.
- [Researcher]:* You'll show the respect to them even if you are unhappy. Is that true for all of you?
- [Group]:* Yes.

Fulfilling a reciprocal contract. A reciprocal contract refers to the feeling of obligation to provide upward care for the older persons, because the adolescents had received care from them. “I must care for them, because they care of me” (Participant 1).

Middle adolescents reflected whether they would continue to care for older persons when they reached independence. Two perspectives emerged: one is that they would not care for the

older persons: “No, I have to work” (Participant 8), while the other perspective is that they had to work to return what had been invested by the older person: “When you old you *have to* work for your grandmother because he worked for you and he cared for you when you was [were] young” (Participant 5). The reciprocal caring contract thus requires returning or reciprocating the care older persons had provided for the younger people: “When you [were] young he cared and he looked for you, maybe when your mother is working ... out there... where you live like in Gauteng” (Participant 4).

Adolescents demonstrated that they are aware that if they give care they may probably receive care in return, even if they are still young and the older persons are their elders: “Even the young kids, if you respect him [them], he [they – the older persons] will also respect you” (Journal Participant 1). One of the participants referred to a personal experience in which he demonstrated instrumental care by cleaning a yard, although he did not specifically refer to the type of care he had reciprocally received: “I felt care at the time of Christmas at night after I cared with the dirty yard I cleaned” (Journal Participant 7).

Emotional care will also be reciprocally provided and received: “Other peoples they listen to you because you listen for them. When you listen for the old people they will listen to you because you listen for them” (Participant 4). Their actions were however expressed as obedience: “Like when you told me take this thing and put there, I will take it and put there” (Participant 4).

Discussion

In relationships, care is usually described as an action that is provided and received (Bowlby, McKie, Gregory, & Macpherson, 2010; Cong & Silverstein, 2012; Litman, 2012; Tronto, 1993; Van der Geest, 2002). In the present study, adolescents positioned themselves as

the recipients of care in relation to siblings and parents (illustrated in Figure 1). In the South African context, it would have been expected that older persons somehow would figure in the descriptions of care experiences, either as recipients or providers of care, because of the prominent role that older persons sometimes play as substitute parents for the younger generations (Oduaran & Oduaran, 2010). This role is played due to the migration of adult children to find alternative income or the untimely demise of adult children relating to HIV/AIDS and other epidemics (Hoffman, 2014; Oduaran & Oduaran, 2010). However, older persons were not initially recognized either as providers or recipients of care. This could be the result of relationships with older persons not really being part of the adolescents' experiential world and that the care adolescents experienced in relationships with siblings and parents satisfied their care needs. Alternatively, the absence could be entrenched as an implicit cultural norm which meant that the adolescents did not even consider more fulfilling care relationships with older persons. Both explanations could be possible in terms of the findings. In the first instance, adolescents may not be giving care to older persons or receiving it from them because they already receive it from their peers and families and they focus more on peer relationships. This possibility is according to Bowden and Smith Greenberg (2010), Earl, Hargreaves, and Ryan (2013) as well as Louw and Louw (2007) not uncommon among people in this developmental phase. In the second instance, younger people's behaviour and motivations for care towards older persons could be driven by implicit cultural norms, which sculpt and direct the care actions a person chooses to perform or not to perform (Bjorklund & Hernandez Blasi, 2012; Bowlby et al., 2010; Deci & Ryan, 2008a; Sung, 2004).

The upward care motivations of adolescents were mostly elicited by external stimuli – responding to requests and observation of older persons struggling. Adolescents were moved

into caring action and provided physical and instrumental care. The motivation of care was described in terms of obedience which forms part of SDT's extrinsic motivation (external regulation motivation type) (Deci & Ryan, 2008a; Ryan & Deci, 2000b). Adolescents in this study also demonstrated physical and instrumental care by taking the perspective of older persons when they noticed that the older persons were struggling. This type of motivation is described as extrinsically motivated (introjected regulation motivation type), because although there is a degree of internalisation and self-determination, their actions were still elicited by external stimuli (Deci & Ryan, 2008b; Ryan & Deci, 2000a).

In addition, adolescents were motivated to provide upward physical/instrumental and emotional care by feeling obligated: to ensure older persons' happiness and satisfaction; from their position as younger people in relation to older persons and by reciprocating care received from older persons bestowed on them. Other African and also American studies (e.g. Aboderin, 2006; Walker, Pratt, Shin, & Jones, 1990) also found obligation as a motive to care. Some researchers clustered obligations to provide care under introjected regulation motivation type proposed by SDT (Deci & Ryan, 2008; MacIntyre & Potter, 2014; Patrick, 2014). Introjected regulation is a motivation type that allows a higher sense of choice and self-determination than external regulation but is still regarded as relatively controlled (Deci & Ryan, 2008a; Ryan & Deci, 2000b). This means that the adolescents still experienced pressure from others to behave in a certain way, even though their actions were more self-determined (Deci & Ryan, 2008b).

The adolescents also felt obligated to return the reciprocal care they received from older persons. In cases where actions were motivated by the reciprocal characteristic of care (e.g., Ghana, Africa; Aboderin, 2006), the individuals were extrinsically moved by the possible care

reward their care behaviour held. The extrinsic motivations were more self-determined when the value of reciprocity had been internalized (England et al., 2012).

Alternatively to obligation as a motive for care actions such as spending time with older persons and gaining an education, other extrinsic motives seemed present that included even higher levels of self-determination (self-endorsement of activities). Participants gained an education to enhance their personal value, but it was still done because the older persons expected it of them and to ensure the older persons happiness. Thus, although adolescents in this study did not demonstrate care being motivated intrinsically, there is some evidence that participants were moved to provide emotional care by higher levels of their own self-determination.

The implications of the findings raise concern about the nature of the intergenerational relations between older persons and middle adolescents and consequently about the care needs of older persons. The reason for this is because intergenerational relations, specifically in the South-African context, are an important source of caregiving (Hoffman, 2014; Roos, in press). From the findings it can be concluded that older persons are not by default the providers or the recipients of these adolescents' care. In addition, adolescents are mostly extrinsically motivated and driven by obedience and feelings of obligation due to their position as younger people; to ensure the happiness and satisfaction of older persons and to reciprocate care. These motivations of care are not typical of the optimal level of self-regulated and self-determined behaviour (Deci & Ryan, 2008a; 2008b). In addition, although middle adolescents' described motivation to care by taking the perspective of older persons' positions it was described in response to external stimuli and not described in terms of self-determined actions or outcomes. Also, only one example was found where emotional care was described in terms of self-determined actions, but

in this case the motivation for the caring behaviour was also informed by the external response of older persons. Intrinsic motivated care would be when adolescents provide care for the inherent fulfilment the action provides (i.e., positive experiences, novelty or genuine interest), and when these actions are self-determined (Ryan & Deci, 2000b). Literature indicates that intrinsic motivation is known to facilitate better quality care (England et al., 2012).

The question that arises is what would happen once the adolescents become more autonomous and move away from this sense of responsibility and obligation. In the light of previous research indicating strained relationships between older persons and young adults in an African context (Mabaso, 2012; Møller & Sotshongaye 2002, Van Dongen 2008), the findings of this research indicate that there is already a misfit between giving and receiving care among adolescents and older persons (De Jager, 2014). In a community that is (true to its African tradition) more prone to focus on promotion of a sense of community, the abovementioned intergenerational relationships serve as a primary source to survival (Oduaran & Oduaran, 2010; Hoffman, 2014; Roos, 2011). If the adolescents' motivations are inclined to be externally motivated, the care will not be likely to sustain (Ryan & Deci, 2000b). A different approach is thus needed to establish what enhances intrinsic motivation for younger individuals and what moves them to internalize the responsibility or at least develop higher levels of self-determination to care for older persons.

Implications and Recommendations

From the literature it was clear that the concept of care is ambiguous (Mentzakis et al., 2011; Van der Geest, 2002; Van der Vyver, 2011) and does not necessarily have the same meaning for everyone. With this said, using the Mmogo-method® (Roos, 2008) assisted the participants to construct or display how they understood care, building on the semi-structured

questions in the journals. For future research it is proposed to include more participants, as well as a wider range of ethnic groups. More deprived communities from different provinces could also be included in the future for a broader overview of South African youth's experiences of care. This study is limited to the experiences of middle adolescents exclusively because it did not include the experiences of the older persons.

Even though these separate experiences are deemed very important, a further study may be considered whereby older and younger participants are grouped together. This will allow researchers the opportunity to see the intergenerational experiences at first hand. If such a study is well facilitated, the participants could simultaneously benefit from data gathering in terms of acquiring insight into intergenerational problems. The findings from this study can thus inform intergenerational programmes for creating interventions. Interventions could focus on building generational intelligence within the distinct generations, because the acquisition of generational intelligence, i.e. when both generations immerse themselves in the other generations' perspective and experiences (Biggs & Lowenstein, 2011), provides an opportunity. Such an opportunity would require establishing effective and supportable interventions which in turn will enable an individual to succeed in a caregiver role. With more insight into the older generation, older persons may become more prominent figures in the adolescents' lives. Furthermore, it is proposed that gratitude as motivation for reciprocal care needs to be taught to adolescents instead of obligation as motivator, because it was found that filial obligation and commitment may diminish with age (Daatland et al., 2012; Silverstein & Giarrusso, 2010). Gratitude as an intrinsic, autonomous motivation type will be more sustainable (Deci & Ryan, 2008a). Gratitude as motivation could also assist in shaping adolescents into contributing individuals of a society; a society which genuinely cares about, and feels a connection with members of the community

(Froh et al., 2010). More autonomous motivation types such as gratitude could also contribute to the overall well-being of givers and receivers of care (Deci & Ryan, 2008a).

Examples of such interventions are information sessions and videos for persons in intergenerational relationships, which include talks or practical demonstrations using puppets or props. Topics for such sessions could range from care needs to the lives of intergenerational others. Another example could be a board game as a form of intervention (e.g. Hewitt, 2014) developed for this context. It could be used specifically to promote altruism and gratitude within intergenerational relationships.

Conclusion

Middle adolescents' motivations for upward care are mainly externally provoked and extrinsically motivated. Even though a measure of autonomy or self-choice emerged from these motivations, care behaviours are more sustainable when intrinsically motivated. Because older persons are often reliant on the younger generation for care, it is important to ensure that the adolescents remain motivated to provide care, even beyond adolescence. With an already existing discrepancy between the generations in terms of comprehending the opposite generations' processes and needs, assistance in this regard is deemed imperative. This means that care providers as well as care receivers would require support if they are to acquire a better mutual understanding that would ensure optimal personal well-being, functional cohesive relationships, and a more satisfying future.

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CRITICAL REFLECTION

This research supported a better understanding of what motivates adolescents from economically vulnerable areas to provide care for older persons. To the best of the researcher's knowledge, studies about adolescents' motivations for upward care in the South African context have not yet been thoroughly explored. Indeed, most studies focus on upward care provided by adult children (e.g., Aboderin, 2006; Knodel & Chayovan, 2009; Szydlik, 2012, etc.). This study therefore makes a contribution to existing literature with regard to upward care provided by adolescents. A further contribution concerns the role of specific motivations as well as motivation types in care in intergenerational relationships, especially in an African context and for the adolescent developmental stage.

Findings revealed that older persons are not uppermost in the minds of the younger generation. When looking specifically at the adolescents' motivations for care it is evident that their care actions mostly stem from an external source and are mostly extrinsically motivated. The types of extrinsic motivations which were mostly identified were external regulation and introjected regulation. These two types are both non-internalized extrinsic motivations or controlled motivation types (Deci & Ryan, 2008a). Only singular incidences of more self-determined extrinsic motivations occurred. The anticipated implications of the findings are explained by Deci and Ryan (2008a). Autonomous motivations (intrinsic motivation and the internalized extrinsic motivation types) are more sustainable, deliver more devoted care providers, and contribute to the psychological well-being of care providers and receivers. Consequently, since care provided because of obedience, perspective-taking, obligation, reciprocity, or a submissive position of the adolescents is seen in terms of extrinsic and controlled motivations, it may also reveal that these motivations are not necessarily as

sustainable as one would hope. These unsustainable motivations may possibly be seen in behaviours of individuals from certain African communities, for example in a study by Hoffman (2014), who explains occurrences where older persons who are in need of care experience a lack of support or care.

Why does it seem that older persons do not figure prominently in the minds of the younger generation? Is it possible that their motivations are mostly controlled types because of the economic situation of the environment, but will the situation be different if individuals had more to give? According to self-determination theory, types of motivations are influenced by the degree to which the needs for relatedness, autonomy, and competence are satisfied (Deci & Ryan, 2008a; Ryan & Deci, 2000a). When examining the phenomenon of older persons' not being noticed in care relationships, it would appear that the adolescents' needs for relatedness are satisfied by other family members and peer groups. Other reasons could be that at their particular stage of development adolescents' focus revolves around peer groups (Louw & Louw, 2007) or it could be due to the internalization of cultural norms. It is possible that the need for autonomy is impaired because the adolescents are dependent (for financial support) on the older person for everything because of their submissive position as a child in this impoverished environment. It is also not certain to what extent decisions are made for the adolescents and if their care provision is regarded as competent. All these factors could have an influence on the type of motivation that drives the adolescents to provide care, as well as on the sustainability of care provision (Deci & Ryan, 2008a).

Care does not only consist of tangible/instrumental care, but also includes an intangible/emotional component (Antonucci, Birditt, Sherman, & Trinh, 2011; Glenn, 2000; Tronto, 2001; van der Geest, 2002). If someone is not able to provide care in terms of physical

help, they can perhaps provide care in terms of time spent together or assisting with an activity. Adolescents have the cognitive capacity to internalize their behaviour regulations, and increasingly so (Deci & Ryan, 2008a). The more internalized behaviour becomes, the more autonomous and sustainable the motivation for care (Deci & Ryan, 2008a). Consequently, the goal of optimal and sustainable provision of care for older persons is definitely possible, but certain changes would have to be made.

It is evident that this research addressed several gaps in the literature by exploring adolescents' motivations for the provision of upward care. The research methodology that was used enabled the research process to elicit valuable and informative data.

Methodology

The phenomenological research design that was applied to this study was appropriate because this study sought to make use of an interpretive process (Creswell, 2012) to gain plausible insight into the nature of the participants' world (Van Manen, 1990), and to understand the hidden meaning within adolescents' lived experiences of care in intergenerational relationships (Grbich, 2013) (i.e., from participants' experiences the researcher proceeded to gain plausible insight into their motivations for care).

Data was collected using the Mmogo-method® as a visual projective data-collection technique. This method provides researchers with a possibility to better comprehend participants' subjective lived relational experiences mentioned above (Roos, 2008). As a projective technique, the visual representations which they constructed of their care experiences formed the basis of the explanations of their experiences. Their innermost experiences and feelings were projected on to what they had creatively constructed. Projective techniques (in this case a constructive type) are a strategy which makes use of visual stimulus to gain access to a person's

hidden thoughts and emotions. Such techniques elicit subconscious internal thoughts and experiences which are in some cases difficult to articulate (Porr, Mayan, Graffigna, Wall, & Vieira, 2011). The Mmogo-method® was thus found to be relevant, because the subjective and “hidden” meanings of experiences are clarified and effectively elicited by means of visual projections. In this way the Mmogo-method® elicited subjective motivations for upward care from the adolescents. Furthermore, the Mmogo-method® was deemed culturally and context-appropriate because it involves using clay, beads and straw, which are simple materials participants are familiar with (Roos, in press). Journals, which served as an alternative data-collection method, provided supplementary data, thus contributing to the trustworthiness of the data overall.

Applying the descriptive phenomenological psychological method (Giorgi, 2012; Roos, in press) with visual and thematic analyses provided more depth and a more grounded analysis than thematic analyses alone (Clarke & Braun, 2013) would have provided. Descriptive analysis allowed the researcher to immerse herself in the data to provide clear summaries of the participants’ experiences of care. This method also included a process which encouraged the researcher to revise the data several times.

Conclusion

This research has addressed clear gaps in the literature, especially with regard to upward care, motivations and intergenerational relationships between members from G1 and G3 in a South African context. The methodology applied to the research process enabled the researcher to acquire relevant data to inform the research question. Adolescents’ motivations for their care actions were mostly controlled and extrinsic motivation types. The findings of this research could inform intergenerational programmes designed to establish optimal and sustainable

provision of care for older persons. These programmes could focus on creating generational intelligence and eliciting gratitude as a motivator for upward care among members of the two generations. Generational intelligence can thus be promoted during interventions and applied to facilitate gratitude as an alternative motivation for care actions.

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