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Caregiver stress in adult care home operators

Reisacher, Sally Ann, Ph.D.
Case Western Reserve University, 1990

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CAREGIVER STRESS IN ADULT CARE HOME OPERATORS

by

SALLY ANN REISACHER

Submitted in partial fulfillment of the requirements for the Degree of Doctor of Philosophy

Thesis Advisor: Claudia J. Coulton, Ph.D.

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Sally Ann Ricekha
CAREGIVER STRESS IN ADULT CARE HOME OPERATORS

Abstract

by

Sally Ann Reisacher

The stress of providing care to others is generally considered to place the caregiver at risk of negative physical and emotional outcomes. This can result in decreased ability to provide care, and can jeopardize the health of the vulnerable person(s) receiving care.

This study of 69 operators of small adult care homes examined the extent to which adult care home operators perceive that they are stressed by their caregiving, and identified factors which correlate with higher levels of stress in home operators.

Correlations were calculated between stress and nine independent variables: age, income, self-reported health, social support, four perceived benefits of providing care, and resident care needs. Only three were found to be significantly correlated with stress. A moderate negative correlation (−.45, \( p < .0001 \)) was found between age and stress, and a low negative correlation (−.25, \( p < .05 \)) was found between the perceived benefit of companionship and stress. Resident care needs were found to be correlated with
stress (0.29, p<0.05), but the subgrouping of resident behavior care needs was found to be even more highly correlated (0.35, p<0.001). Regression analysis revealed that these three variables explained over 32% of the variance in the perceived stress of operators interviewed.

Home operators were asked to identify experiences which they found most stressful. The most common category of response related to caring for residents, followed by resident behaviors and confusion, interaction with others, and restrictions on the operators' lives. When asked what they found most satisfying about operating a home, the most frequent responses were helping those in need, seeing improvement in the residents, having affectionate relationships with residents, and receiving praise for their services. Home operators were also asked what programs or services would reduce their stress. The most common responses were financial assistance, programs for residents, clearer regulations and additional training.

An eleven-item Adult Care Home Operator Stress Scale was developed to measure perceived caregiver stress. A modified psychiatric hospital acuity measure was utilized to measure extent of resident care needs. Both measures hold promise for use in future research with adult care home operators.
To my family,

and to

the residents of adult care homes

in Ohio

and throughout the country.
PREFACE

Since 1982, I have worked with adult care home operators in Cleveland, Ohio, providing them with education, training, and technical assistance programs. In that time, I have worked with over 500 adult care home operators who care for approximately 2500 residents. Most of these homes have been small, family homes in which the operator provides care to five or six residents in his or her own home.

From these experiences, I have learned that constraints on the operator of a small adult care home can negatively impact the quality of care provided to his or her residents. When home operators lack funds, home repairs may not be made, and a well-balanced and appealing diet may not be provided. When home operators lack knowledge, poor care decisions can be made, or inadequate care given. When a home operator is unfamiliar with community resources, residents may go without needed services.

To maximize the quality of care provided to the residents of these homes, needs and problems of the operators must be addressed, so that they are enabled to give the best care possible. This study was conducted to determine whether some home operators are experiencing the problem of high levels of perceived stress, and to identify tangible ways in which stress can be prevented or ameliorated. It is my hope
that the results will be utilized to improve the quality of care for and quality of life of some of the hundreds of thousands of adult care home residents nationally.

The contributions of many individuals and organizations supported the development and completion of each phase of this research project. I am grateful to Georgia Aネットzberger, Ph.D., for sharing her ideas and thoughts with me when I first began to develop this research topic in 1986. I also offer my thanks to the Long Term Care Ombudsman Program of Cleveland for supplying information about adult care homes in Cuyahoga, Geauga, Lake, Lorain and Medina counties. This information was used as the basis for developing the sample of home operators surveyed.

The sixty-nine interviews included in this study were conducted by the Rev. Joan Huff. I am grateful to Joan for the skill and precision with which she conducted these surveys, and for the sensitivity and understanding which she demonstrated toward the home operators whom she interviewed. My sincere thanks also go to the adult care home operators who participated as subjects for this research. I appreciate the time which they gave to be interviewed, and the candor with which they shared their feelings and experiences.

I also want to express my appreciation to the committee which has guided me through the dissertation process: Sharon
Milligan, Ph.D. and Alvin Schorr from the Mandel School of Applied Social Sciences, and Elizabeth Adams, M.S.N., R.N., of the Frances Payne Bolton School of Nursing. Special thanks go to the Chairperson of my committee, Claudia Coulton, Ph.D., whose input and guidance have been invaluable.

Finally, my deepest thanks and appreciation go to my family, my friends, and my colleagues at the Lutheran Metropolitan Ministry Association. Without their ongoing support and encouragement, I could not have undertaken or completed this study.
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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

With the growing number of frail and impaired adults in this country needing some kind of long-term care, increasing attention is being paid to alternatives to institutionalization. One long-term care placement alternative is adult care homes, which are community residences that provide room, board, 24-hour supervision and personal assistance to vulnerable, dependent adults who may be physically and/or emotionally impaired. It has been estimated that over 100,000 of these homes operate throughout the United States, providing care to an estimated one to one and one-half million adults (U.S. House of Representatives, 1981).

Adult care homes are a critical part of the long-term care continuum. Adult care homes provide 24-hour community-based care to dependent adults, many of whom are low-income and whose only other care alternative would be nursing home placement financed by the Medicaid program. Further development of long-term care placement options such as adult care homes in Ohio is being encouraged to help prevent unwarranted intermediate care facility placements (Health Systems Agency of North Central Ohio, 1985). In turn, by enabling vulnerable adults to avoid unnecessary nursing home placement, adult care homes contribute to the containment of
long-term health care costs. For each one hundred Supplemental Security Income recipients in Ohio who can reside in adult care homes instead of intermediate care facilities, the state saves an average of one-half million dollars per year (Warner and Smith, 1985).

Although some adult care homes are large facilities with paid staff, most adult care homes are smaller, family type homes in which the home operator provides care to residents in his or her own home (Mor, Sherwood and Gutkin, 1986). In these family homes, the operator is almost always the sole caregiver for the residents. As a result, the kind of care received by the residents, and, ultimately, the ability of adult care homes to function as an important long-term care option, is dependent upon the home operator’s ability to continue providing adequate support to his or her residents.

The process of providing care to others, whether it be an informal caregiving arrangement for a family member or a professional caregiving responsibility for a patient, is generally considered to place the caregiver at risk of negative physical and emotional outcomes. Numerous studies have been conducted on family caregivers to determine the levels of stress—also known as "caregiver burden"—experienced, as well as caregiver and care recipient characteristics which correlate with higher levels of stress.
Many studies have also been done in the nursing field to document the stress which caring for patients has on the caregiving professional. The studies done with families and those done with nurses indicate that people who provide care to others do experience stress as a result of their caregiving functions.

The consequences of this stress for the caregiver and the care recipient have been found to be serious. Studies of families have indicated that the stresses of caregiving can ultimately stress care providers to the point that they are no longer able to continue offering support (Crossman, et.al., 1981; Klein et.al., 1967; Stephens & Christianson, 1986). In the nursing profession, job-related stress has been connected with decreased morale, absenteeism, diminished energy levels and decreased productivity (Bailey, 1980). Stress that is severe or which lasts long enough can cause the body to become physically exhausted and unable to respond (Bailey, 1980). If stress can impact caregivers to the extent that their effectiveness and ability as care providers is diminished, then the well-being of the vulnerable people for whom they provide care is placed in jeopardy.

In a caregiving continuum, adult care home operators fall somewhere between family caregivers and health care professionals, containing elements of both. Home operators provide care in their homes to multiple dependent adults for
whom they care on a 24-hour a day basis, and it could be expected that adult care home operators would experience stress from caregiving just as family caregivers and professional caregivers do. The stress of caregiving has the potential to diminish the effectiveness and skill with which adult care home operators provide services to their dependent residents, thereby placing resident physical and emotional well-being at risk. The importance of adult care homes in the long-term care continuum and the large number of vulnerable residents who rely on support from adult care home operators highlight the importance of developing a causal explanation for caregiver stress which will enable the identification of factors or circumstances which result in higher levels of perceived stress.

This study examined the extent to which adult care home operators perceive that they are stressed by their caregiving, and identified factors which correlate with higher levels of stress in home operators. These data were collected for the purpose of identifying practice and policy interventions which may promote the safety and well-being of the vulnerable residents of these homes by reducing the level of stress experienced by the home operators.
CHAPTER II

BACKGROUND OF THE PROBLEM

Adult Care Homes and Caregiver Stress

No previous studies have been done on caregiver stress in adult care home operators, and no theory bases have been developed to model such stress. In the absence of research and theory on caregiver stress in adult care home operators, research and theory on family caregivers and nurses have been utilized to construct a conceptual framework to address the issue of caregiver stress in adult care home operators. It is, however, important to clearly delineate ways in which adult care home operators are similar to and different from both family caregivers and nurses before engaging in such analysis. These similarities and differences will impact the way in which this research and these theories can be applied to the operators of adult care homes.

The family atmosphere of small adult care homes makes them seem quite similar to a family caregiving situation. Recent studies have revealed that family-type feelings and relationships do develop between the home operator and his or her residents, and that the home could be considered a surrogate family (Newman and Sherman, 1977; Newman and Sherman, 1979-1980; Sherwood and Morris, 1983). The close relationships and family-type feelings that develop are elements of adult care homes that make these long-term care
facilities particularly effective in meeting the emotional as well as physical needs of their residents.

Adult care home operators do not, however, have the intimate familial relations extending over many decades that a family caregiver would have, and which impact the family caregiver's perception of his or her situation. Studies have consistently revealed that changes in long-established family relationships resulting from the care recipient's decline and the care provider's assumption of caregiving duties are correlated with level of stress felt. Crossman et al. (1981) found that the loss of closeness to a loving spouse and role conflict from a shift in the original role with the spouse were sources of stress for the caregiver. Cantor (1983) found that sense of responsibility to family and intergenerational conflicts were associated with increased stress. Brody (1985) considers that caring for a parent raises a dependence/independence dialectic for the caregiver which is stressful. The importance of these shifting relationships is reflected by items included in many family caregiving stress assessment instruments. These items probe for family members' feelings of anger, guilt, and frustration over their changing relations with their relatives. Such family relationship changes would not occur in the adult care home operator's relationship with his or her residents.
Operating an adult care home is also a business choice which the operator makes, and the operator decides when to begin taking residents to provide care and when to stop taking residents. It is a completely autonomous choice to enter into the caregiving process. Family members also have freedom of choice of whether or not to provide care, but it is not a choice about whether or not to enter a business. It is, instead, a choice about whether or not and to what extent the individual will provide care to a family member who needs assistance. Issues and emotions such as guilt and filial responsibility play a part in the relative's decision to be involved or not to be involved. In many cases, family members have to give up employment to provide care, as opposed to the adult care home operator who actually enters a business by choosing to provide care.

Adult care homes also differ from family caregiving in that the home operator is accepting money for the provision of care. Most home operators report that their revenues for providing care do not cover their expenses, and the majority of home operators receive only slightly more than $300 per month to provide care (Mor, et.al., 1986), so for most home operators the financial gains of providing care are minimal. Nonetheless, adult care homes are a paid, non-familial caregiving arrangement, and as such differ from the family caregiving situation.
Like much family caregiving, adult care home operators provide round-the-clock supervision and care. However, adult care homes provide care to multiple, unrelated adults for a fee. As such, it may appear that adult care homes are more analogous to hospital nursing than to family caregiving. But just as adult care home operators differ from family caregivers in several important respects, they also differ from nursing professionals in several ways. Although adult care homes operate as a caregiving business, the home operators generally do not have the professional skill and training of a nurse. Studies of adult care homes throughout the United States have consistently revealed that adult care home operators have little or no training in providing care (The American Red Cross, 1987; McClave, 1982; Newman and Sherman, 1977; Stone, Newcomer and Saunders, 1982). Caregiving functions also differ among home operators and nurses, in that most states do not permit adult care home operators to provide skilled nursing care to residents. For the most part, adult care home operators are providing food, room, cleaning, laundry, 24-hour supervision and personal care assistance with functions such as bathing, dressing and grooming. Nurses, while carrying out some of these caregiving functions, also engage in the provision of skilled nursing care services to critically and chronically ill patients. The professional nursing role and the stresses
which result from transitions to and from the professional role would not be issues in the adult care home setting (Chiriboga and Bailey, 1986; Jones, Janman and Rick, 1987).

The work setting as a source of stress also differs for nurses and adult care home operators. Studies of hospital nurses indicate that factors relating to the institutional structure, administration and authoritarian management of hospitals are associated with higher levels of stress (Bailey, Steffen and Grout, 1980; Chiriboga and Bailey, 1986; Jones, Janman and Rick, 1987). The adult care home operator providing care in his or own home would not confront the stresses imposed by issues related to institutional administration and management.

Provision of care in an adult care home is similar to family caregiving in that care is provided in the home to a person living as part of the family, with many of the same emotional bonds that exist among relatives. Adult care provision is also similar to the nursing profession in that it is a chosen activity for which financial remuneration is made. Yet adult care homes differ from both family caregiving and nursing care. It is with these similarities and differences in mind that application of existing research and theory can be made to adult care home operators.
Historical Developments in Caregiver Stress

The first recognition given to the negative impacts of family caregiving came in the late 1950's and early 1960's with the increasing trend in the de-institutionalization of the mentally ill. Studies were done which followed the patient into the community to determine consequences of discharging the mentally ill from institutions to the homes of their relatives. These first studies examined the social impact that having a relative with mental illness at home had on the family, as well as the impact that the family had on the patient (Freeman & Simmons, 1961; Grad & Sainsbury, 1963; Kelley, 1964; Yarrow, Schwartz, Murphy & Deasy, 1955).

Numerous studies of families caring for mentally ill relatives were conducted through the 1970's. These studies examined the differing impacts of various institutional and community treatment modalities on the patient and his or her family (Herz et.al.,1976; Platt and Hirsch, 1981). In many of these studies, the mentally ill person was viewed as almost inevitably bringing stigma upon him or herself and his or her family members. This stigma, and the resultant feelings of shame and inferiority which it imposed upon family members, was viewed as the "cost" of caregiving for the family (Cummings & Cummings, 1965; Freeman & Simmons, 1961; Swanson & Spitzer, 1970).

Grad and Sainsbury (1963) advanced the field by
broadening the conceptualization of caregiver burden to include all costs experienced by the caregiving family, including impact on income, employment, health, social and leisure, domestic routine, and relations with neighbors, as well as the emotional distress experienced as a result of a relative's disturbing behaviors. This multi-dimensional conceptualization of caregiver burden was a departure from the early studies which focused on unidimensional conceptualizations of the impact of caregiving.

The multi-dimensional conceptualization of caregiver burden has led to further conceptual consideration of the manner in which the dimensions impacted by caregiving should be grouped and evaluated. Some researchers combine the multi-dimensional aspects which caregiving impacts into a single broad concept of caregiver burden which is then operationalized as the summary score on a scale of various negative impacts that caregiving may have (Fitting, et.al., 1986; Pratt, 1985; Robinson 1983; Zarit, et.al., 1980; Zarit, et.al., 1986).

Hoenig and Hamilton (1967), and later Herz et.al. (1976) and Platt and Hirsch (1981) combined the dimensions on which caregivers could experience negative impacts into two types of caregiver burden. Objective burden was thought to includes the activities, events, and happenings associated with caregiving, such as changes in amount of leisure time,
health, finances, and privacy. Subjective burden was thought to include the emotions, attitudes and feelings of the care provider, such as anger, frustration, and sadness. Those researchers who have conceptualized caregiver burden as having the dimensions of objective burden and subjective burden have found different incidence of these two types of burden, and differing correlates for each. Caregiver-related factors such as age, gender, income, and amount of social support have been found to be associated with subjective burden. Caregiving tasks performed by the care provider and negative or abnormal resident behaviors have been correlated with objective burden (Herz et.al., 1976; Hoenig & Hamilton, 1967; Montgomery, et.al., 1986; Thompson & Doll, 1982).

Other researchers have conceptualized caregiver stress as being multi-dimensional. Stephens and Christianson (1985) have studied stress in terms of elements of emotional strain, physical strain, and financial strain. They found that females perceived caregiving as significantly more emotionally and physically straining than did male caregivers. Provision of personal care and average hours a day devoted to caregiving were also both significantly related to levels of emotional and physical strain. Relationship to care recipient was found to be related to all three aspects of stress. Self-reported health was found to be significantly related to physical strain, while caregiver
income was identified as being related to perceived financial strain.

Similarly, George and Gwyther (1986) researched stress in family caregivers by assessing impact of caregiving on four areas of the caregiver's life: physical health, mental health, finances, and social activities. This study incorporated the three areas used by Stephens and Christianson (1986), but also established an additional dimension relating to the caregiver's social interactions with others. The relationship of the caregiver to the care recipient was found to be significantly related to all four areas.

Novak and Guest (1989) have developed a five-subscale Caregiver Burden Inventory based on factor analysis of a 24-item scale used to assess family caregiver stress. The five factors which were identified in analysis were time-dependence burden, developmental burden, physical burden, social burden, and emotional burden. These findings expand the research of Stephens and Christianson (1986) and George and Gwyther (1986) by statistically identifying five of the dimensions of stress in family caregivers. Their categories of time-dependence burden, developmental burden, and social burden appear to more sensitively assess the areas identified in George and Gwyther's single category of social interactions. Time-dependence burden was defined as
restrictions on time, which would impact the time spent in social interactions as measured by George and Gwyther. Developmental burden included stresses from the caregiver's feelings about his or her life situation, including ability to socialize. Social burden involved stresses from problems in personal relationships.

Increasingly, studies of caregiver burden have shifted focus from care of the mentally ill to care of an elderly relative (Montgomery, et al., 1985; Robinson, 1983). Especially prevalent are studies of the impact of caring for a relative with Alzheimer's Disease or other dementing disorder (Fitting, et al., 1986; George and Gwyther, 1986; Pratt et al., 1985; Zarit, et al., 1980; Zarit, et al., 1986). This shift corresponds to the growing interest in long-term care for this country's growing elderly population.

The history of research on caregiving stress in nurses is much shorter than that of family caregivers; research on work-related stress in nurses is a relatively new phenomenon (Bailey, Steffen and Grout, 1980). Nursing stress and subsequent "burnout" have recently become major issues of concern for the nursing profession. "Burnout" has been defined as the physical and emotional exhaustion and loss of compassion and respect for clients which accompany extensive job-related stress (Cronin-Stubble and Rooks, 1985). Because of their importance for the well-being of patients and nurses
alike, nursing stress and nursing burnout have been identified as among the top ten research priorities for the nursing field (Lewandowski and Kositsky, 1983).

Studies of nursing stress have examined correlates of stress and burnout (Chiriboga and Bailey, 1986; Cronin-Stubbs and Rooks, 1985; Jones, Janman and Rick, 1987), primary sources of stress for nurses (Grout, Steffen and Bailey, 1981), and the differences in stress among nurses working on different types of hospital units (Chiriboga and Bailey, 1986; Cronin-Stubbs and Rooks, 1985). These studies have indicated that nurses do experience emotional stress from their professional caregiving situation, and that occupational stress is associated with burnout (Cronin-Stubbs and Rook, 1985). A variety of factors, both personal and environmental, have been found to explain significant amounts of variance in burnout, including the work environment, personal demographics, work stressors (Chiriboga and Bailey, 1986), social supports (Chiriboga and Bailey, 1986; Cronin-Stubbs and Rooks, 1985), and coping (Chiriboga and Bailey, 1986).

Existing Theoretical and Conceptual Frameworks

Several theoretical perspectives have been advanced to explain causality of caregiver stress in family caregivers. One of these perspectives is based in exchange theory, which
holds as its general proposition that humans avoid behavior which they perceive as costly, and will seek circumstances which they perceive will provide rewarding statuses, relationships, interactions and feeling states to the end that profits are maximized (Nye, 1982b). This theory assumes that humans are social beings, and that social life requires reciprocity among its participants. The assumption is also made that human beings are rational, and are able to consider the rewards and costs of various situations within the constraints of the information which they possess. Upon weighing the rewards and costs of a situation, the theory maintains that an individual will act in a way that will maximize his or her rewards or minimize his or her costs.

A number of researchers who have studied family caregiver stress have implicitly utilized exchange theory to guide their causal explanations. Grad and Sainsbury (1963) define burden as any costs to the family of having the emotionally impaired relative at home. Early studies of the deinstitutionalized mentally ill at home considered that the family member elicited a cost—in most cases, shame—to his or her family members (Cummings & Cummings, 1965; Freeman & Simmons, 1961; Swanson & Spitzer, 1970). Thompson and Doll (1982) talk about the "price" that caregiving imposes on the family.

George (1987) has most specifically addressed exchange
theory as a causal explanation of caregiver burden. She emphasizes that social relationships are based on a fairly equitable exchange, but that the situation of caring for an impaired family member requires the acceptance of a long-term imbalance in the exchange relationship. The caregiver provides constant care, but receives minimal rewards in exchange. The feelings of burden emerge from the difficulty that exists in trying to accept a permanent imbalance which violates the basic exchange principle by which social interactions are guided. This imbalance creates the base of caregiver burden; the level of caregiver stress results from the extent of the costs imposed on the care provider. Among caregivers, those who experience greater costs from care provision will have higher levels of perceived stress, such as caregivers with poor health or those who gave up jobs to provide care.

A second theory which has been used to explain the cause of caregiver burden is that of role theory. Role theory maintains that society is based on a large number of status systems. Within these systems, individuals are thought to hold a variety of statuses, both those which are ascribed because of what the person is (such as age, sex, and religion) and those which are achieved, and which are allocated based on what the individual can do (Deutsch & Krauss, 1965). These fixed positions within status systems
carry with them certain expectations and demands, as well as sanctions which enforce them. Roles are the enactment of the various statuses that a person occupies. Role problems can emerge if there is role ambiguity, role conflict, role incongruity, role overload, or role over- or under-qualification. Any or all of these role problems can lead to role strain, which consists of subjective feelings of frustration, tension, or anxiety (Hardy, 1978).

Some researchers who have studied family caregiving have cited role theory as a causal explanation for caregiver burden. Among those citing it directly are Crossman, et.al. (1981), who state that role strain resulting from the many competing role demands of the caregiver leads to guilt and to feelings of burden. Horowitz (cited in Stephens & Christianson, 1986) and Brody (1985) describe the role conflicts that can result when the duties of the caregiver role interfere with the carrying out of expectations of other roles such as those of employee, parent and spouse. Fitting, et.al. (1986) also discuss role theory in relation to caregiver stress, commenting that the response to the caregiver role is based on factors relating to both ascribed and achieved statuses that the individual maintains. For example, a woman becoming a caregiver may be resuming a nurturing role of which they are tired, while a man may for the first time be assuming a caregiving role which he
considers new and challenging.

Fitting, et al. (1986) have explored the connection between exchange theory and role theory in explaining the causes of caregiver burden, by describing the impact that the exchange relations involved in one's roles can have upon their perception of burden. Fitting, et al. (1986) are not alone in their merging of these two theories. Hardy (1978) states that role relationships may be examined as social exchanges involving costs, rewards, and outcomes, and that role encumbrants would be expected to avoid excessively costly relationships. Nye (1982a) has also blended the two theories, stating that the efficacy of exchange relations is dependent upon the role competence of group members.

Although both exchange and role theories have been used to explain caregiver strain in family caregivers, neither is really appropriate for use in application to adult care home operators. Exchange theory has been applied to stress in family caregivers because of the inequitable relation that exists between the caregiver and care recipient. In adult care homes, this relationship is not so inequitable. The resident in an adult care facility pays a monthly rate in exchange for room, board and services, so the care provided by the home operator does not go completely unreimbursed as it often does with family caregivers. Many adult care home operators are reimbursed at a very low rate—approximately
$10.00 per day for 24-hour care and services— but they still receive a level of return in the exchange relationship that is much greater than that received by most family caregivers.

Role theory also does not fit adult care home operators as well as it fits family caregivers. Role theory posits that family caregivers experience negative physical and emotional outcomes of caregiving because they experience role conflict and role overload, and because they are forced to take on a role status which they may not want. Although adult care home operators may experience some role conflict with other responsibilities of spouse and parent, they will not typically experience the role conflict that comes from the competing demands of their job and their caregiving function. For the adult care home operators, their caregiving function is almost always their only job, so conflicts are unlikely. Additionally, the adult care home operator chooses his or her caregiving role, and so it is also unlikely that the operator will experience the stress that results from having to adopt an undesired role status.

Stress theory has also been used to explain caregiver strain in family members, as well as in nurses. The interactive model of stress theory has been most extensively advocated by Lazarus (Lazarus, 1961; Lazarus, 1967; Lazarus, 1976), but it has also been supported by numerous other researchers (Hamilton, 1979; McGrath, 1970; Fleming, Baum and
Singer, 1984). The interactive tradition of stress theory has emphasized the interaction of the stressful agent(s) and the human system of appraisal and evaluation (Fleming, Baum and Singer, 1984). If the individual appraises a situation as stressful, he or she will initiate coping responses, which are an effort to resist or overcome the stressor.

Figure 1 shows interactive stress theory as it has been modeled by researchers who have studied stress reactions. The interactive process is initiated when a stressor is introduced to an organism. The individual experiencing the stressor then makes an appraisal of the extent to which the situation is considered stressful.

This appraisal process is impacted by characteristics of the individual doing the appraising. McGrath (1970) points out that the attributes of the organism will affect the criteria used to assess stressors and will impact the
appraisal made of them. Bailey (1980) also notes that individual differences play a vital role in the way in which appraisals are made. Vogel, Raymond and Lazarus (1959) found that an individual's feelings of helplessness and his or her motivations in a situation will impact the appraisal made.

Although the experience of stress is affected by the appraisal process, it is not completely determined by that process. Both McGrath (1970) and Fleming, Baum and Singer (1984) have noted that the interpretation of physical stressors may increase or decrease their immediate effects, but that a physical stressor will also have a direct stressing impact upon the individual. This is an important consideration to take into account when examining the stresses of caregiving, because the stressor of caregiving often contains a physical care component. This physical stressor will impact the extent to which a caregiver perceives his or her situation as stressful.

If the situation involving the stressor is perceived as stressful by the individual, then a coping response is believed to be initiated as a means of handling the stress demands placed upon the individual (Fleming, Baum and Singer, 1984; Lazarus, 1976). Individual differences are also believed to impact the coping mechanisms used to manage the stressful situation. Several researchers, including Anderson (1977), Lefcourt, Martin and Saleh (1984), and Parkes (1984)
have found that individual differences in locus of control will impact the type of coping strategy utilized. Behaviors associated with Type A personalities have also been found to correlate with types of coping methods used (Pittner and Houston, 1980; Vickers, Hervig, Rahe, and Rosenman, 1981).

Stress theory has been applied widely to family caregiver stress. Brody (1985), Crossman (1981), Fengler and Goodrich (1979), Pratt et al. (1985), Robinson (1983), and Zarit et al. (1980) have all studied caregiver stress in family caregivers from the perspective of stress theory, considering that caregiving imposes physical and emotional stressors which may be perceived by caregivers as stressful, and which may be moderated by differing coping strategies utilized by the caregivers.

Stress theory has also been used extensively in studies of nursing stress. Numerous studies, including those done by Bailey (1980), Bailey, Steffen and Grout (1980), Chiriboga and Bailey (1986), Cronin-Stubbs and Rooks (1985), and Jones, Janman and Rick (1987) have examined the stressors imposed by nursing, considering the types of stressors most highly associated with high levels of perceived stress and the coping strategies utilized by nurses.

Because high levels of stress have been found to interfere with productive thinking and skilled behaviors (Lazarus, 1976), can lead to unrealistic behaviors (Lazarus,
1976), and can promote the development of serious health problems (Bailey, 1980), the level of stress perceived by a caregiver could be considered an important element impacting the extent to which caregiving tasks are adequately carried out. High levels of stress could also be thought of as level of caregiver distress, based on the negative potential outcomes that stress can have on a caregiver.

Proposed Theoretical Framework

Analysis of the theories which have been used to explain caregiver stress in family caregivers and in nurses suggests that stress theory is the most useful theoretical basis from which to consider caregiver stress in adult care home operators. Because it has been used widely in application to both family members and nurses, it would seem to be valid to apply it to a part of the caregiving spectrum which falls between informal family caregiving and professional health care provision. Unlike exchange theory and role theory, whose applications to caregiver stress have focused on elements of role conflict and financial exchange which are not relevant to adult care homes, stress theory provides a more general model of stress which can be readily applied to a variety of caregiving situations.

These principles of exchange theory can be used to broaden the conceptualization of motivation and situational
appraisal in stress theory. Exchange theory posits that all humans are motivated to seek rewards, and that humans will examine the costs and benefits of all situations in which they are involved with the goal of maximizing their benefits. Stress theory maintains that the motivations of an individual are critical to the way in which the person appraises the situation, because frustration of a motivation or goal is thought to result in an appraisal of stressfulness (Vogel, Raymond and Lazarus, 1959). Since, according to exchange theory, all humans are motivated to seek rewards, it can be concluded that stressor situations in which those rewards are not attained will be appraised as more stressful than situations in which rewards are received. Thus, it could be postulated that the exchange nature of a relationship will effect the appraisal made of a situation, and so it becomes important when testing the theoretical model to identify the extent to which rewards are being received by the individual in the stressor situation.

The Conceptual Model of Caregiver Stress in Adult Care Home Operators

This research was guided by the conceptual model presented in Figure 2. Based on the proposed theoretical framework, the conceptual model suggests that the extent to which the adult care home operator appraises his or her
situation as stressful will depend upon a combination of factors, including the

**Figure 2. Conceptual Model of Stress in Adult Care Home Operators**

A stressor of combined resident care needs and individual elements which are anticipated to impact the appraisal made, including perceived benefits, caregiver characteristics, and the amount of support that the caregiver has. The model focuses only on part of the theoretical stress model, and it does not include elements of coping and physiological stress responses.

Adult care home operators are faced with having to meet the care needs of one or more impaired adults, and so the
primary stressor for home operators will be conceptualized as the combined care needs, both physical and emotional, of all residents in a given home. It is projected in this model that the level of resident care needs will impact the extent to which adult care home operators will appraise their situation as being stressful. Care recipient factors which family caregiver research has connected with objective burden are ability to do activities of daily living (Robinson, 1983), emotional/behavioral problems (Stephens & Christianson, 1986), and cognitive impairment (Robinson, 1983; Zarit et al., 1986). Nursing stress research has also revealed a strong connection between patient care needs and stress experienced (Chiriboga and Bailey, 1986; Grout, Steffan and Bailey, 1980).

Individual characteristics of the adult care home operator have also been included in the model, because these individual differences are theorized to contribute to differential appraisals of a stressful situation. Several caregiver characteristics have been shown to be related to perceived stress in family caregivers, including age (Montgomery et al., 1985; Fitting et al., 1986; Crossman et al., 1981), income (Herz et al., 1976; Montgomery et al., 1985; Robinson, 1983), and self-reported health (Pratt et al., 1985; Crossman et al., 1981). Studies of stress in nurses have also shown a significant correlation
between age and burnout (Chiriboga and Bailey, 1986).

Because exchange theory maintains that all humans are motivated to maximize benefits in their interpersonal relations, and because the thwarting of goals and motivations is stated in stress theory to result in appraisals of stress, the perceived benefits of adult care home operators have also been included in this model. Specific categories of benefits have been taken from a study by Eckert, Namazi, and Kahana (1987) in which a sample of 177 home operators were asked to identify their primary reason for continuing to operate a home. The responses focused on four primary perceived benefits which are included in the model: financial benefits, satisfaction from helping others, being able to work in one’s own home, and companionship.

Social support for the caregiver is shown in this model to impact the extent to which caregiving tasks cause shifts which result in perceived stress. Although Pratt et.al. (1985) and Zarit et.al. (1986) found that the amount of formal and informal support received did not correlate with burden, Montgomery et.al. (1985) found that the number of others assisting in care was negatively correlated with burden and George & Gwyther (1986) discovered that those caregivers who perceived a need for more support had higher levels of burden. In this model, the presence of support persons who assist in the provision of care are posited to
impact the appraisal made of the caregiving situation.

Research Questions

Studies that have been done on caregiver stress have focused extensively on the experience of burden among family members caring for impaired relatives, as well as upon the stress experienced by professional health caregivers such as nurses. However, no study has ever examined the extent of caregiver stress in the operators of adult care homes, or the types of caregivers that experience higher levels of stress.

This exploratory study examined, for the first time, the occurrence and extent of caregiver stress experienced by the operator/caregivers of adult care homes, and the caregiver characteristics and resident care needs that account for the variation in level of stress experienced. The research focused on the following questions:

1. To what extent do adult care home operators appraise their situation as being stressful?
2. What adult care home operator characteristics are associated with high levels of perceived stress?
3. Does the presence of caregiving support impact the level of perceived stress?
4. Is total perceived benefit related to level of stress?
5. Are certain perceived benefits more highly associated with
lowered stress than others?

6. Are increased resident care needs associated with higher levels of stress?

7. What experiences do adult care home operators consider to be stress-producing?

Background and Rationale

It is important to explore these research questions about caregiver stress in adult care home operators, both to learn the extent of caregiver stress experienced by adult care home operators, and to begin to understand the home operator characteristics, supports, perceived benefits, and resident care needs which are associated with these care providers experiencing more or less caregiver stress.

Most of the studies that have been done with adult care homes are descriptive in nature, providing demographic characteristics of the residents, the homes, and, to a more limited extent, the home operators/caregivers (Copenhaver, 1986; Eckert et.al, 1987; Goodman & Pynoos, 1986; Mor et. al., 1986; Newman and Sherman, 1977; Pynoos & Goodman, 1986; Sherman and Newman, 1977; Steinhauer, 1982). These studies differentiate two basic types of homes: the small, family type home in which care is provided to an average of four or five residents by an individual in her/his home, and the larger facility in which paid staff who do not live in the
home provide the care. Nationally, the small family homes are the most common type of home (Mor et al., 1986).

The research which has been done has indicated that home operators in family homes tend to be women age 50 and over, most of whom are not married and do not have children living in the home (Eckert et al., 1987; Newman & Sherman, 1977; Newman & Sherman, 1980). Most are recruited to provide care by friends or relatives who are already providing care to residents in their own homes, and not by agencies (Newman and Sherman, 1977). Many caregivers have had some kind of work experience in a health care setting, but few have had any formal training in providing care (Eckert et al., 1987; Newman & Sherman, 1980). Close relationships have been identified between the caregivers of adult care homes and their residents, with most home operators viewing residents as part of the family (Newman and Sherman, 1977; Newman and Sherman, 1980). No previous studies have considered the consequences experienced by adult care home operators as a result of providing 24-hour care to one or more dependent adults in their homes.

Limited research has been done on caregiver burden in foster parents. Fanshel (1966) did interview foster fathers to determine what aspects of foster parenting they found to be inconvenient, and the extent to which they felt inconvenienced. The factors most commonly identified as
producing "some inconvenience" were disturbance of sleep, restrictions on going out, and trips to clinics and other places.

Considerably more research has been done on caregiver stress in family members who are caring for a physically or emotionally impaired relative, and on nurses caring for patients in acute care settings. These literature bases will be used to develop areas for examination in the proposed study of stress in adult care home operators.

There is a lack of clarity in the literature about the family caregiver factors which are correlated with higher levels of perceived stress. Age is one example. Fitting et. al. (1986), Montgomery et. al. (1985), and Robinson (1983) have found that age is significantly negatively correlated with feelings of subjective burden in family caregivers. The researchers attributed this relationship to the fact that younger caregivers have responsibilities other than caregiving, such as children, house payments, and so on which contribute to caregivers’ stress. The proposed theory would maintain that the additional life stresses experienced by younger caregivers would cause the caregiving situation to be appraised as more stressful. Conversely, Pratt et. al. (1985) and Thompson and Doll (1982) found that age was not significantly correlated with subjective burden.

Montgomery et.al (1985) found that income was one of the
best predictors of burden, being positively significantly correlated with measures of subjective burden. This was attributed to the additional strain that younger, employed caregivers would experience. Robinson's (1983) findings that strain was positively significantly related to employment support this conclusion. These studies indicate that the strains of being employed while also trying to provide care to a family member would cause the caregiver to perceive the caregiving relationship as more stressful. Pratt et al. (1986), however, found that subjective burden was not significantly affected by income.

Similar disagreement exists over the relationship between caregiver self-perceived health and stress. Pratt et al. (1986) found caregiver self-reported health to be negatively, significantly related to subjective burden, and Stephens and Christianson (1986) found that self-reported overall health was related to perceived physical strain. Robinson (1983) found no relationship between self-reported health and perceived stress. Theory base would support a relationship between health and perceived burden, since a perception of poorer health would be expected to impose stresses on the caregiver which may lead them to perceive their caregiving situation as more stressful than they would if they were in better health.

Research on stress in nurses has focused largely on task
and environmental factors relating to higher levels of stress, but they have revealed some caregiver characteristics which are associated with higher levels of stress. Chiriboga and Bailey (1986) found that age was negatively significantly correlated with level of burnout. This would indicate that experience may be a factor in the extent to which a situation is appraised as stressful, and that more experienced nurses perceive situations as less stressful. This is supported by Chiriboga and Bailey’s additional finding that the number of years that a participant had been a nurse was negatively significantly correlated with the level of burnout experienced.

Social supports have been found to be important relative to amount of perceived stress in both family caregivers and nurses. In family caregiving literature, Montgomery et.al. (1985) found that the number of others assisting in care was negatively correlated with burden and George & Gwyther (1986) discovered that those caregivers who perceived a need for more support had higher levels of burden. However, Pratt et.al. (1985) and Zarit et.al. (1986) found that the amount of formal and informal support received did not correlate with stress reported by family members. In nursing studies, Cronin-Stubbs and Rooks (1985) found that affective social support was negatively significantly correlated with level of stress.
Although it is conceivable that the level of stress could, at times, impact the amount of social support sought and received, these family caregiver and nursing stress studies assume that it is the level of social support which affects the perceived stress level of the caregiver. The results of these studies indicate that the presence of either affective or task-oriented support causes caregivers to perceive their situation as less stressful. In the case of task-oriented support, this may be because the presence of support provides for a reduction in the severity of the stressor because caregiving tasks are shared.

Few studies in either family caregiving or nursing have addressed the issue of what caregivers find to be beneficial about their caregiving situation. In nursing, Grout, Steffan and Bailey (1981) examined the sources of stress and the sources of satisfaction in nursing. Interestingly, two of the greatest sources of stress—patient care and interpersonal relations—were also two of the greatest sources of satisfaction. In adult care home literature, Eckert et al.‘s 1987 study explored home operators’ reasons for continuing to take residents into their homes. The most commonly cited reasons were personal satisfaction, helping others, love of people, prevention of loneliness, the desire to stay at home to work, and financial benefits. Although the Eckert et al. study did not examine the relationship
between benefits and stress, it did begin to identify the benefits which, according to the combined exchange and stress theory, will be important factors in the extent to which care provision is considered to be stressful.

The care needs of either the family member or the patient also seem to be associated with levels of stress experienced by family members and nurses. This is not an unexpected association. Theory would hold that the stressor—in this case, combined resident care needs—would have an impact on the appraisal made about the stressfulness of the situation. In the family caregiving literature, the amount of assistance the impaired person needs with activities of daily living was found by Robinson (1983) to be significantly correlated with level of caregiver strain, although Zarit et. al (1980) found that it did not correlate with level of stress. Caregiver tasks have been found in several studies to correlate with objective burden (Cantor, 1983; Montgomery et. al, 1985). Nursing research is much more unequivocal about the impact of patient care needs on stress. Chiriboga and Bailey (1986) and Bailey, Steffan and Grout (1980) found that patient care demands were associated with higher levels of stress or burnout for nurses.

To planners and program developers, the extent to which adult care home operators experience stress should be a matter of great concern. A variety of outcomes of stress in
general have been well documented. Lazarus (1976) states that stress increases the potential for maladjustment in handling problems of living. Stress emotions are very demanding of time and can interfere with productive thinking and skilled behaviors. Stress emotions also "mobilize desperate and often unrealistic efforts to get the individual out of jeopardy" (p. 71). These decreases in productive thinking and skilled behavior, as well as the possibility of desperate and/or unrealistic behavior, may lead to neglectful or abusive resident care. Additionally, stress has been associated with the development of a variety of organic disturbances, including coronary thrombosis, cancer, hypertension and peripheral vascular disease (Bailey, 1980). This is also a matter of concern, because a caregiver who has exhausted him or herself to the point of illness or inability to respond will clearly not be able to provide adequate resident care.

It is essential to gain an understanding of the nature of adult care home operator stress, and to understand factors which are associated with higher and lower levels of perceived stress. It is only through such understanding that potential high-stress caregiving situations can be identified and altered to prevent negative outcomes for the caregiver and, subsequently, for the residents.
CHAPTER III

METHODOLOGY

A cross-sectional study of 69 adult care home operators from Cuyahoga, Geauga, Lake, Lorain, and Medina counties was conducted to gather information about perceived stress, as well as information about resident care needs, perceived benefits of providing care, supports available, and caregiver factors of age, income, and self-perceived health. The adult care homes included were those homes which were private residences, in which the owner/renter lived and in which he/she provided the care to his/her residents without the assistance of any paid staff. Information was gathered during in-person interviews with the home operator at the adult care home. In cases where there was more than one caregiver in the home, such as when a husband and wife operated the home, the primary caregiver was interviewed.

Hypotheses

Seven research questions and their related hypotheses served as the focus for this research:

1. TO WHAT EXTENT DO ADULT CARE HOME OPERATORS APPRAISE THEIR SITUATION AS BEING STRESSFUL?

Hypothesis: This is a descriptive question; no hypothesis was generated.
2. WHAT ADULT CARE HOME OPERATOR CHARACTERISTICS ARE ASSOCIATED WITH HIGH LEVELS OF PERCEIVED STRESS?

**Hypothesis 2.1:** Age will be significantly related to perceived stress in a curvilinear fashion, with stress declining with increasing age for caregivers age 65 and under, and stress increasing with increasing age for caregivers over age 65.

**Rationale:** Previous studies indicated that age is negatively correlated with perceived stress in family caregivers (Montgomery et al., 1985; Fitting et al., 1986). It has been concluded that this relationship exists because younger caregivers have stresses in addition to the stress of caregiving. Such stresses might include children, house payments, and other factors. Chiriboga and Bailey (1986) found that in nurses, too, age was negatively correlated with stress. In nurses, it is thought that this relation exists because younger nurses tend to be more inexperienced, which makes elements of caregiving seem more stressful.

It is thought that, with increasing age, many of these roles and additional stressors are eliminated. However, Crossman et al. (1981) have found that elderly women who are serving as caregivers are at especially great risk for extra stress, because the demands of caregiving are superimposed upon the stresses and costs of their own aging process. These extraordinary stressors which younger and older
caregivers experience were hypothesized to result in a curvilinear relationship between age and perceived stress, with burden decreasing as the caregiver increases in age, until the point at which the advancing age of the caregiver again creates added stressors which cause the caregiver to appraise his or her situation as more costly.

Hypothesis 2.2: Caregiver income, exclusive of income generated by providing care, will be negatively correlated with perceived stress.

Rationale: Research which has been done on family caregivers has indicated that income is positively related with perceived stress in caregivers. Montgomery et.al. (1985) found that income is positively correlated to family caregiver stress, and Robinson (1983) found that employment is positively correlated with family caregiver stress. In both cases, it was concluded that working—which provided the higher incomes—created additional role demands and stresses for the caregiver in addition to the caregiving role, thereby increasing the perceived stress of providing care. However, for adult care home operators, these findings would not be directly applicable. Because the provision of care in an adult care home includes 24-hour supervision and services, the primary caregiver in the adult care home virtually never has a job outside of the care home. It is thus unlikely that a higher income for an adult care home operator would be
related to outside employment, and so those added stressors would not be involved.

More likely to be an important factor for adult care home operators is the finding of Herz et.al. (1976), who discovered that worry about financial problems is one of the elements which contributes significantly to feelings of stress in family caregivers. It is anticipated that the stresses of managing on a low income, in addition to the stresses of caregiving, will result in an increased perception of stress among adult care home operators. In this study, income was considered to include only that income which is exclusive of monies made from caregiving. This was for two reasons: first, most caregivers receive just enough money from residents to cover the expenses of providing care, and so in many cases no expendable income is generated through caregiving, and, second, it is difficult to obtain an accurate figure on income generated by residents annually, because when residents move elsewhere, one or more beds may be vacant at any one time, generating no funds for a period of time.

**Hypothesis 2.3:** Self-reported health will be negatively related to perceived stress.

**Rationale:** Pratt et.al. (1985) have found that family caregivers’ self-reported health is negatively correlated with subjective burden, and Stephens and Christianson (1986)
identified that caregivers with poorer health had higher levels of physical strain. Poor health provides additional stress for the caregiver, and increases the likelihood that caregiving will be perceived as stressful. Just as Crossman et.al. (1981) identified that older family caregivers facing the stresses of declining function and health in addition to the stresses of caregiving have increased perceived stress, so those adult care home operators who perceive themselves as having poorer health which they must manage in addition to their caregiving role were expected to have increased caregiver stress.

3. DOES CAREGIVING SUPPORT IMPACT THE LEVEL OF STRESS EXPERIENCED?

**Hypothesis 3.1:** The number of hours each week during which caregiving assistance is received from one or more family members will be negatively correlated with the perceived stress of the adult care home operator.

**Rationale:** Research on family caregivers has indicated that social supports are related to the amount of stress perceived. Montgomery et.al. (1985) found that the number of others assisting in care was negatively correlated with burden and George & Gwyther (1986) discovered that those caregivers who perceived a need for more support had higher levels of stress. In nursing studies also, support was found to be related to diminished appraisals of stress.
Cronin-Stubbs and Rooks (1985) found that affective social support was negatively significantly correlated with level of stress.

4. IS TOTAL PERCEIVED BENEFIT RELATED TO LEVELS OF STRESS?

Hypothesis 4.1: The amount of benefit experienced by adult care home operators will be negatively correlated with their level of perceived stress.

Rationale: Exchange theory maintains that all humans seek rewarding situations and avoid situations for which there are no benefits (Nye, 1982b). If a caregiver receives few or no rewards from his or her caregiving arrangement, then the profit-seeking motive is thwarted and perceived stress is expected to increase. George (1987) has specifically addressed the cost-benefit analytic nature of humans and of the family caregiver role. She states that the long-term family caregiving relationship is typically imbalanced, with the caregiver giving a great deal but receiving minimal rewards. She concludes that this imbalance of costs and benefits comprises the basis of caregiver stress. It was hypothesized that increased perceived rewards would lessen perceived levels of stress.

5. ARE CERTAIN PERCEIVED BENEFITS MORE HIGHLY ASSOCIATED WITH LOWERED STRESS THAN OTHERS?

Hypotheses: No specific hypotheses were generated for this
research question; it was an exploratory question.

**Rationale:** It is possible that the various perceived benefits are rewarding in different ways to different caregivers, and that the extent to which perceived benefits are associated with level of stress may vary from benefit to benefit. Nothing is known, however, about the differential way in which financial, personal and emotional benefits will be weighed by home operators in determining the perceived benefit and the subsequent perceived stress. As a result, analysis of data involved regressing stress on perceived benefit as a single, cumulative concept, as well as regressing stress on each of the separate elements of benefit.

6. **ARE INCREASED RESIDENT CARE NEEDS ASSOCIATED WITH HIGHER LEVELS OF PERCEIVED STRESS?**

**Hypothesis 6.1:** Level of combined resident care needs will be positively correlated with levels of perceived stress.

**Rationale:** Robinson (1983), in studies of family caregivers, found that the extent to which family members could do their own activities of daily living was negatively significantly correlated with the extent to which the caregiver perceived the situation as stressful. Nursing research has also revealed that the extent of patient care needs is positively correlated with perceived stress (Chiriboga and Bailey, 1986; Bailey, Steffan and Grout, 1980).
7. WHAT EXPERIENCES DO ADULT CARE HOME OPERATORS CONSIDER TO BE STRESS PRODUCING?

Hypotheses: No specific hypotheses were generated for this research question; it was an exploratory question.

Rationale: No previous research had been done on the experiences or events that adult care home operators consider to be stress producing. Nursing literature has revealed a number of work setting and environmental factors which are considered stress-producing by nurses, such as type of unit, patient demands, and distractions (Bailey, Steffan and Grout, 1980; Chiriboga and Bailey, 1986; Cronin-Stubbs and Rooks, 1985). However, the caregiving situation of the adult care home operator is unique and has not been carefully studied before. It was not possible to develop quantitative categories which would adequately assess all of the varied aspect of the caregiving situation experienced by adult care home operators. As a result, home operators were asked open-ended interview questions to obtain data to address this research question.

Measures

This study included the examination of ten variables. The caregiver characteristics of age, income, and self-perceived health all served as independent variables, as did the the existence of caregiver support and resident
care needs. Perceived benefits consisted of four separate independent variables which, in analysis, were used individually and in combination as a single benefit score. Perceived stress was the dependent variable. An interview schedule, included as Appendix A, was developed with measures for each of the independent variables and for the dependent variable.

Home and Operator Characteristics: The initial portion of the interview schedule asked home operators for information about themselves and the operation of their homes. To gather data on the independent variables of age and income, home operators were asked their age in years at the time of the interview and their monthly income apart from money received for caring for their residents. Existence of caregiving support was determined by asking the number of hours per week they received assistance from a family member or members.

Self-reported health was operationalized as the response which the home operator provided when asked whether he/she would consider his/her current health as very good(5), good(4), satisfactory(3), not so good(2), or bad(1). Health measures using this type of single-item self-assessment have been found to be highly correlated with objective health conditions (Ferraro, 1980; Fillenbaum, 1979; Linn and Linn, 1980).

Perceived Benefits: Perceived benefits were measured using
categories of benefits identified by Eckert et al. in their 1987 research on adult care homes. In that study, adult care home operators were asked to report the primary reason that they continued to take in residents. Of 177 responses, 124 fell into the four primary categories: financial benefit, satisfaction at helping others, ability to work in one's own home, and the companionship provided. For each category, home operators were be asked to rate on a scale of 0 (not at all) to 5 (a great deal) the extent to which operating a home has benefitted them in the specified way.

**Resident Care Needs Survey Instrument:** Resident care needs were measured using an adapted version of the C.F. Menninger Memorial Hospital's Nursing Patient Classification Form (Schroder and Washington, 1982). This instrument is a patient classification, or "acuity", system which was designed for a use in a psychiatric setting. Use of acuity measures is growing in popularity in hospitals as a means for determining combined patient care needs and the subsequent levels of staffing needed to meet those care needs. By assigning scores to patients based on their individual care needs and totalling those scores for all patients on a given unit or ward, acuity measures permit hospitals to determine the number of nursing care hours required to meet those needs (Sovie, Tarcinale, Vanpuyeel, and Stundin, 1985; Unger, 1985). A psychiatric acuity measure was selected for use because
measures for psychiatric settings take into account "interactional time" which nurses spend meeting the psychosocial health care needs of residents, such as dealing with residents who are depressed or withdrawn (Purdue and Dick, 1986). Because adult care home operators spend time dealing with the psychosocial needs of residents as well as providing tangible task-oriented assistance, a patient classification system from a psychiatric facility was selected for use in this study.

The Menninger instrument was developed at the Menninger Memorial Hospital in Topeka, Kansas, where it is used to determine staffing needs for nurses. It consists of ten general categories of types of assistance that a resident may need, including Supervision, Meals, Hygiene, Activities, Level of Responsibility, Risk, Medications, Physical Problems, Behavioral, and Extra. Each patient is rated on each category. In the first eight categories, the resident receives only one score for each category, based on the extent of assistance or care required. In the "Behavioral" and "Extra" categories, the resident is given points for each item which is applicable.

For use in this study, the acuity measure was modified to be more appropriate for adult care homes. Some items within categories were removed because the care described would never be provided in an adult care home (for example,
use of cold wet sheet packs). The modified version has eight categories, with the Activities and Risk categories having been dropped because of inappropriateness for measurement in the adult care home setting. Within the eight categories, individual resident scores can range from 7 to 37. The caregivers were asked to identify the level of care needed in each category for each resident living in the home at the time of the interview. Scores for each resident were totalled, and then all resident scores were summed for a combined measure of resident care needs.

Adult Care Home Operator Stress Scale: Caregiver stress was measured utilizing an instrument adapted from an existing scale of family caregiver stress. Virtually all family caregiver stress scales include items that focus on factors that are irrelevant to adult care home operators, such as items about feelings of guilt over the changing relationship that the family members have, or items about feelings about having to give up employment to provide care. As a result, no instrument was appropriate for use with adult care home operators without some alterations being made.

The measure used in this study was adapted from Robinson’s (1983) Caregiver Strain Questionnaire. Robinson’s index has been found to have a Cronbach’s alpha of .86 with family caregivers, and has been tested for construct validity. This index was selected because it includes items
which assess the extent to which the caregiver appraises the caregiving situation as stressful, as well as items which assess the direct physical impact of the caregiving experience.

Robinson’s original index consisted of thirteen questions which ask about physical and emotional stresses experienced from care provision. The respondent states yes or no whether each statement applies to him or her, for a total possible score of 13. To modify the index, one item relating to the stress of caregiving as it conflicts with work was dropped, since such a conflict is uncommon in adult care home operators. Also, in an effort to make the scale more relevant to adult care home operators and to thus hopefully increase content validity, two questions relating specifically to the home operators’ stressing experiences with agencies and residents’ families were added.

So that the index would be more sensitive to individual experiences, the caregivers were asked the frequency with which they experienced each item, rather than responding in a yes-no format. Scores for each statement were made on a five-point scale: "rarely or never"(1), "a little of the time"(2), "sometimes"(3), "often"(4), and "most of the time"(5). Possible scores on this 14-item version of the scale ranged from 14 to 70.

Data received from interviews with home operators was
used to test the reliability of the stress scale. Statistical analysis revealed that the scale had the greatest internal consistency when only eleven of the fourteen items were used. Upon dropping one question about sleep disturbance and the questions about frustration with residents’ families and with agencies, the scale had a standardized item alpha of .86. Pearson correlation coefficients were calculated for these eleven items with the total score, and all correlations were found to be positive and significant (p<.0001) with the smallest correlation being .46. Additionally, T-tests conducted on the highest 25% of scores and lowest 25% of scores on each item revealed that each of the eleven items contributes statistically significant discriminant power to the scale.

Based on these findings, the eleven-item scale of stress was used as the measure of the dependent variable of home operator stress. Scores on this Adult Care Home Operator Stress Scale can range from 11 to 55. In application to this sample of home operators, the scale was found to have a mean of 21.76, a variance of 70.6, and a standard deviation of 8.4. All data analysis was conducted using this eleven-item scale.

**Home Operator Perceptions of Stressful Aspects of Caregiving:** These perceptions were measured through content analysis of responses which caregivers provided to three open-ended
questions about aspects of being an adult care home operator which they consider to be most stressful, aspects of their work which they find most enjoyable and rewarding, and what services they believe could assist them in their jobs as care providers.

Study Design

This was a cross-sectional, survey study of the operators of 69 adult care home operators from Cuyahoga, Geauga, Lake, Lorain, and Medina counties in northeast Ohio. Information was gathered during in-person interviews with the home operator at the adult care home using the study’s interview schedule. In cases where there was more than one caregiver in the home, such as when a husband and wife operated the home, the primary caregiver was interviewed.

The interview schedule was pre-tested on five home operators with varying levels of education who resided in different counties. Pre-testing was done to assure clarity of questions and reasonableness of length and content. All interviews done after the pre-tests were conducted by one paid interviewer. Prior to conducting any surveys, the interviewer was carefully trained in the application of the interview schedule.

Sampling

To achieve satisfactory statistical power for this
study, a sample size of 76 home operators was identified as optimal. Because there were no previous studies of the effect of the independent variables on stress adult care home operators on which to base a power analysis, a relatively weak effect of .20 explained variance was assumed. With ten independent variables—age (counting as two variables in anticipation of using a dummy variable to represent a curvilinear relationship), health, income, caregiving support, four perceived benefits, and resident care needs—a sample of 76 at an alpha of .05 would give the multiple regression test a power of .80 (Cohen, 1977). The power would increase if fewer than the ten independent variables were used.

The adult care homes which comprised the sampling frame were those homes in Cuyahoga, Geauga, Lake, Lorain and Medina counties which were private residences, in which the owner/renter lived and in which he/she provided the care to one or more residents. Names of adult care homes that operated in these counties and which met these criteria were obtained from The Nursing Home Ombudsman in Cleveland, which had the most complete centralized record of homes in northeast Ohio of any group or organization. Since 1981, the Nursing Home Ombudsman had diligently conducted ongoing efforts to identify all operating adult care homes in the five county region. Homes had been identified by contacting
hospitals, county Departments of Human Services, and other agencies which place into adult care homes to determine what facilities are in operation. Programs which license and approve specialized types of homes, such as the Mental Health system, the Mental Retardation system, the Veterans Administration, and the Ohio Department of Human Services, were contacted regularly for updated lists of facilities. Newspaper advertisements soliciting placements of elderly clients were also reviewed and receive follow-up to determine if the home is an adult care home. Finally, known home operators themselves often provided information about newly opened homes of which they are aware.

In 1984-1985, the Nursing Home Ombudsman utilized the State Data Exchange tapes to further expand its base of information about operating adult care homes. These computer records reflect the location to which every Supplemental Security Income (SSI) check in Ohio is sent. Special records were created for the Ombudsman program's five-county service area which showed all addresses to which three or more SSI checks are sent. Follow up of these print-outs revealed only five homes which the Ombudsman program had not already identified through its other methods.

At the outset of the study, 96 adult care homes meeting the selection criteria were known to operate within the five county area. Conformity with selection criteria was
determined by contacting all adult care homes in the five-county area one month prior to the start of the study. During that telephone contact, home operators were asked the number of residents for whom they were caring, whether they were providing care in their own home, and whether they had any paid staff to assist them.

It had been planned that the sample of 76 homes would be selected at random from the available pool of 96 homes. However, it was possible to do only 69 interviews with home operators. Because of the fluid nature of the adult care home business, the number of homes in operation changes on an almost daily basis. When contacted for interviews, thirteen of the 96 homes were out of business, and five homes had no residents. Five additional homes were dropped because of inability to contact the home operator after at least ten tries at different times of day and night over a period of two months. It was assumed that these facilities had no residents, since no contact could ever be made with anyone at the homes. Four home operators who were contacted refused to participate. Caregivers were contacted first by letter about the study, and were then contacted by telephone to request an interview.

The impact of this decrease in sample size on statistical power for the multiple regression analysis was minimal. Assuming the use of all ten independent variables
in the regression equation at an alpha of .05, a weak effect of .22 could be detected with a power of .80 (Cohen, 1977). Use of fewer independent variables in the regression equation would result in even greater power.

Protection of Human Subjects

No risks were incurred by the participating adult care home operators selected for inclusion in the sample of this study. The potential benefits to the home operators participating, and for all adult care home operators, include the potential development of programs and policies which could ameliorate the perceived stress of home operators. Results should also be of great value to agencies which recruit, train and monitor home operators, and which place residents into adult care homes. Information about the caregiver factors, supports and perceived benefits which affect the level of stress will help these agencies identify home operators who are at risk of high levels of stress, and can provide the necessary interventions for those operators or, if necessary, can counsel them out of the business of providing care. An understanding of the resident care needs which are associated with higher levels of stress should also be important to monitoring and placement agencies, helping them to identify and avoid resident mixes which are likely to be especially stressful for operators.

Prior to undertaking any portion of the interview with
home operators, the interviewer sought verbal consent from
the home operator. Verbal consent was used because it was
anticipated that being asked to sign a formal consent form
would be frightening and threatening to many of the care
providers. An information form summarizing the study and
explaining the subject's rights was sent to all subjects with
the initial letter inviting their participation in the study.
Because of the limited literacy of many operators, the
interviewer offered to read the information form to each home
operator participating. The interviewer answered any
questions the home operator may have had about participation
in the study, and the care provider was asked to provide
verbal consent to begin the interview. Additionally, at the
outset of the interview, the interviewer reminded the home
operators that they could choose not to answer any question
which they did not want to answer. Confidentiality was
protected by using only code numbers to mark interview
schedules, and by presenting only aggregate data at the
conclusion of the study. Home operators were informed of
these measures to protect confidentiality in the study
summary sheet and again verbally by the interviewer.
Reliability and Validity of Design

Reliability

Careful attention was given to the structure and wording of the interview schedule to ensure that administration was uniform across subjects. The interview schedule was developed to include a word-for-word narrative which the interviewer used in all applications of the survey. The hired interviewer was trained to follow the wording and to not deviate. The interviewer was also trained to return the subject to the question at hand if the subject’s conversation wandered.

Validity

A number of threats to external validity existed with this design. The first of these was selection, which potentially operated at two different levels. First, there was likely to be a selection bias in the homes recorded in the files of The Nursing Home Ombudsman (NHO) from which sampling was done. The homes on record were, for the most part, homes which were known to hospitals and social service agencies throughout those counties. It is possible that homes which were not known to such agencies differ in some important respect from the homes known to these organizations. In the effort to control this threat, NHO carries on diligent, on-going searches for all types of homes. In spite of NHO’s efforts to make their files as
comprehensive as possible, it can never be known whether all types of homes and care providers were included. As a result, the generalizability of the results will be limited to homes such as the ones known to NHO.

Selection also posed a potential threat to external validity based on caregiver decisions of whether they participated in the study or not. Those caregivers who chose to participate may differ from those who did not participate in some significant way which would affect the generalizability of the findings of the study. To avoid this selection threat to validity as much as possible, every possible effort was made to encourage the home operators selected in the initial sample to actually be interviewed. The initial contact letter and summary of the study were carefully worded to minimize the home operators’ anxiety and to emphasize the importance of their participation and sharing of their expertise. Only four potential subjects refused to participate in the study, minimizing the effect of this threat to validity.

A final threat to validity was systematic mortality. Adult care homes are far more transient in nature than other types of long-term care facilities such as nursing homes. A home can open in one day, and it can also close in one day. Homes constantly go into business and go out of business during any given period of weeks or months. It was possible
that the caregivers who were part of the initial sampling pool and who went out of business during the course of the study differed from those who remained in business in some important way, such as the home operator's level of perceived stress. Most importantly, it may have been the homes in which the care provider's perceived stress was very high that were most likely to go out of business. As a result, the large number of homes which went out of business before the interviews began could impact the generalizability of the results.

Data Analysis

The Statistical Package for the Social Sciences-X was used in analysis of the quantitative data obtained through interviews with the adult care home operators. Frequency distributions were compiled for each of the variables in the study. Pearson product-moment correlation coefficients and scatterplots were computed to determine whether hypothesized linear relationships existed. Multiple regression analysis was also used to determine the relative amount of variance which each of the independent variables explain in the dependent variable perceived stress.

Content analysis was utilized to assess responses to open-ended questions in the interview schedule. Frequency distributions were then calculated for each of the groupings
of responses.
CHAPTER IV

FINDINGS

Characteristics of Adult Care Home Operators and Their Homes

The study sample was composed of 69 adult care home operators from Cuyahoga, Geauga, Lake, Lorain and Medina counties in northeast Ohio. Tables 1 and 2 show the characteristics of those home operators who were included in this sample. Overwhelmingly, the subjects were female, comprising 98.6% of the total. The average age was 54 years, and the operators ranged in age from 28 to 79 years old.

The majority of subjects were married, and more than 32% had one or more children living in their home with them. Almost three-fourths of the subjects received help in providing care to their residents from one or more family members; on the average, operators were getting 46.6 hours of this assistance each week. More than 85% of the participating home operators receive some income from some source other than providing care to residents. Amount of outside income ranged from nothing up to $3000.00 per month.

More than half of the operators indicated that they had participated in some type of formal caregiving training, primarily provided by agencies with which the operators...
Table 1. Characteristics of Adult Care Home Operators

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>( N )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>98.6%</td>
<td>(68)</td>
</tr>
<tr>
<td>Male</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>50.7%</td>
<td>(35)</td>
</tr>
<tr>
<td>Black</td>
<td>47.8%</td>
<td>(33)</td>
</tr>
<tr>
<td>Asian</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>53.6%</td>
<td>(37)</td>
</tr>
<tr>
<td>Single</td>
<td>2.9</td>
<td>(2)</td>
</tr>
<tr>
<td>Divorced</td>
<td>20.3%</td>
<td>(14)</td>
</tr>
<tr>
<td>Widowed</td>
<td>17.4%</td>
<td>(12)</td>
</tr>
<tr>
<td>Separated</td>
<td>5.8</td>
<td>(4)</td>
</tr>
<tr>
<td>Have One Child or More Living at Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>36.2%</td>
<td>(25)</td>
</tr>
<tr>
<td>No</td>
<td>63.8</td>
<td>(44)</td>
</tr>
<tr>
<td>Receive Caregiving Assistance from One or More Family Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>73.9%</td>
<td>(51)</td>
</tr>
<tr>
<td>No</td>
<td>26.1</td>
<td>(18)</td>
</tr>
<tr>
<td>Have Had Formal Caregiving Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58.0%</td>
<td>(40)</td>
</tr>
<tr>
<td>No</td>
<td>42.0</td>
<td>(29)</td>
</tr>
<tr>
<td>Have Been Employed in Health Care Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>60.9%</td>
<td>(42)</td>
</tr>
<tr>
<td>No</td>
<td>39.1</td>
<td>(27)</td>
</tr>
<tr>
<td>Self-Reported Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td>40.6%</td>
<td>(28)</td>
</tr>
<tr>
<td>Good</td>
<td>46.4</td>
<td>(32)</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>8.7</td>
<td>(6)</td>
</tr>
<tr>
<td>Not So Good</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Poor</td>
<td>0.0</td>
<td>(0)</td>
</tr>
</tbody>
</table>
associate. Over sixty percent of the subjects stated that they
had had some employment in a health care setting; on the average,
the operators had 4 years of health care employment apart from the
operation of their homes.

Table 2. Characteristics of Adult Care Home Operators

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>69</td>
<td>54.0</td>
<td>11.6</td>
<td>28</td>
<td>79</td>
</tr>
<tr>
<td>Hours of Caregiving Assistance Received Weekly From Family</td>
<td>63</td>
<td>46.6</td>
<td>65.0</td>
<td>0</td>
<td>168</td>
</tr>
<tr>
<td>Years of Health Employment</td>
<td>67</td>
<td>4.0</td>
<td>6.1</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Monthly Income (Apart from Income from Residents)</td>
<td>48</td>
<td>909.10</td>
<td>793.65</td>
<td>0</td>
<td>$3000.00</td>
</tr>
</tbody>
</table>

Characteristics of the homes which the 69 study participants operated are presented in Tables 3, 4, and 5. The majority of homes were within Cuyahoga county, and most were located in urban areas. Years in operation for the homes spanned almost three decades, ranging from just one year in business to as many as thirty years. The average home size was small, with the mean being 3.5 residents. The smallest homes had just one resident, while the largest number of residents indicated by any home operator was fourteen residents. On the average, these homes could take
Table 3. Characteristics of Adult Care Homes

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Where Home is Located</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>78.6%</td>
<td>(53)</td>
</tr>
<tr>
<td>Geauga</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Lake</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Lorain</td>
<td>13.0</td>
<td>(9)</td>
</tr>
<tr>
<td>Medina</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Setting of Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>72.5%</td>
<td>(50)</td>
</tr>
<tr>
<td>Suburban</td>
<td>14.5</td>
<td>(10)</td>
</tr>
<tr>
<td>Rural</td>
<td>13.0</td>
<td>(9)</td>
</tr>
</tbody>
</table>

over 5 residents, and capacities ranged from one to thirty adults. Resident ages varied broadly from 22 years to 101 years, with the mean resident age being 66.1 years.

The charge for care varied broadly across facilities, with charges as low as $150.00 per month and as high as $1300.00 per month. On the average, residents were paying $488.37 per month for their care.

Residents in these homes received a variety of services in return for their monthly payments. Almost all facilities provided residents with three meals a day, laundry, and cleaning. In cases where three meals were not provided, the operators specified that it was because the residents were at workshops or senior centers for their lunches.
Table 4. Characteristics of Adult Care Homes

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years in Operation</td>
<td>69</td>
<td>7.7</td>
<td>6.1</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Current Number of Residents</td>
<td>68</td>
<td>3.5</td>
<td>2.0</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Maximum Resident Capacity</td>
<td>69</td>
<td>5.2</td>
<td>4.0</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Monthly Charge for Care</td>
<td>67</td>
<td>$488.37</td>
<td>209.26</td>
<td>$150.00</td>
<td>$1300.00</td>
</tr>
<tr>
<td>Average Resident Age</td>
<td>67</td>
<td>66.1</td>
<td>1.8</td>
<td>22</td>
<td>101</td>
</tr>
</tbody>
</table>

Operators who did not do resident laundry and/or cleaning emphasized that these were services which they would normally expect to provide, but that social workers had instructed the young residents in their homes to do these activities for themselves as a means of promoting their independence.

Assistance with personal care tasks such as bathing, dressing and grooming was provided by most home operators interviewed, as were 24-hour supervision in the home and supervision of resident medications. The least frequently offered service was transportation, yet it was still made available by more than half of the operators.
Table 5. Services Provided to Residents

<table>
<thead>
<tr>
<th>Service</th>
<th>% Providing This Service</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Meals Per Day</td>
<td>95.7%</td>
<td>(66)</td>
</tr>
<tr>
<td>Laundry</td>
<td>95.7</td>
<td>(66)</td>
</tr>
<tr>
<td>Clean Resident Living Areas</td>
<td>84.1</td>
<td>(58)</td>
</tr>
<tr>
<td>Transportation</td>
<td>66.7</td>
<td>(46)</td>
</tr>
<tr>
<td>Personal Care Assistance</td>
<td>95.7</td>
<td>(66)</td>
</tr>
<tr>
<td>24-Hour Supervision</td>
<td>97.1</td>
<td>(67)</td>
</tr>
<tr>
<td>Supervise Resident Medications</td>
<td>97.1</td>
<td>(67)</td>
</tr>
</tbody>
</table>

Operator Characteristics and Stress

The first research question posed by this study asked the extent to which adult care home operators appraise their situation as stressful. It was hypothesized in conjunction with this question that home operators would perceive their situations as stressful, and that the levels of stress perceived would vary. Analysis of the frequency distribution for the variable of stress supported this hypothesis. In a possible stress scale score range of 11 to 55, the home operators interviewed had actual scores ranging from 11 to 43, with a standard deviation of 8.4. The mean stress score was 21.8

The second research question guiding this study queried which home operator characteristics were associated with high levels of perceived stress. Three hypotheses relating age,
income apart from fees for caregiving, and self-reported health to level of stress perceived by the home operator were generated based on theory and on previous caregiver stress research with families and nurses. The data relating to these hypotheses are shown in Table 6.

The first hypothesis was that age would be significantly related to perceived stress in a curvilinear fashion, with a negative correlation existing for caregivers age 65 and under, and a positive correlation existing for caregivers over age 65. Pearson product-moment correlations and scattergram plots revealed that a significant relationship did exist between stress and age, but that the relationship was linear rather than curvilinear. A moderate correlation of -.45 (p<.0001) was found to exist between age and stress, indicating that level of perceived stress decreased as home operator age increased.

These findings of a negative correlation between age and stress in adult care home operators parallel findings from research done on both family caregiving and nursing stress. In family caregiving studies, both Robinson (1983) and Montgomery et.al., (1985) found that age was significantly negatively correlated with stress. Likewise, Chiriboga and Bailey (1986) found that age and years as a nurse were negatively correlated with burnout. It is possible that, as posited in studies of families, the younger adult care home
operators have other stressors such as small families, mortgages, and so forth which increase their overall perceived level of stress. It is also possible that, like nurses, adult care home operators become more confident as they gain experience, and so their tasks as caregivers are perceived as less stressful. Home operator age and years in operation were found to be moderately significantly correlated at .47 (p<.0001) indicating that older home operators had been running facilities longer than younger operators. It was also found that years in operation was negatively significantly correlated with perceived stress (-.27, p<.05). The experience gained over time by older home operators may have increased their knowledge and confidence, thereby resulting in decreased levels of perceived stress.

The second hypothesis within this research question held that caregiver income, exclusive of income generated by providing care, would be negatively correlated with subjective burden. Pearson correlations conducted with these two variables revealed that no significant relationship existed between the two (-.15, p=.32), meaning that the hypothesis was not supported. These results parallel findings from studies with family caregivers which indicated that income level and financial stability were not related to level of stress experienced (Cantor, 1983; Pratt et.al., 1985).
Interestingly, age shared a significant moderate correlation of -.36 (p<.02) with the variable non-caregiving income, and a significant moderate correlation of -.49 (p<.0001) with the monthly rate that the operator charged, indicating that older home operators in the sample were getting lower monthly incomes than younger operators, and that they charged lower rates for their services than did younger operators. Since older operators perceived significantly lower levels of stress, and since they received lower monthly incomes and rates of payment for their care, these data further support findings that lower financial resources did not contribute significantly to increases in perceived stress.

The third and final hypothesis relating caregiver characteristics and stress maintained that the home operators' self-reported health would be negatively related to perceived stress. Pearson correlations revealed that no significant relationship of any type existed between self-reported health and stress, meaning that this hypothesis also was not supported. Not surprisingly, a significant relationship was found to exist between age and self-reported health; a weak relationship of -.30 (p<.02) indicated that older home operators reported somewhat poorer health than did younger home operators. In spite of having poorer self-rated health, the older home operators still experienced lower
levels of stress than did younger, healthier caregivers.

Table 6. Correlations of Home Operator Characteristics and Perceived Stress

<table>
<thead>
<tr>
<th></th>
<th>Stress</th>
<th>Age</th>
<th>Self-Reported Health</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.45*</td>
<td>1.00</td>
<td>-.30*</td>
<td>-.49**</td>
</tr>
<tr>
<td>Income</td>
<td>-.15</td>
<td>-.36*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Reported Health</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05  **p < .001

Caregiving Support and Stress

The third research question in this research asked whether caregiving support impacts the level of stress experienced by the home operators. It was hypothesized that the number of hours each week during which one or more family members assisted in the provision of resident care would be negatively significantly correlated with perceived stress. In actuality, the number of hours of assistance received weekly from family members was not significantly correlated with scores from the Stress Scale. Pearson’s correlation between stress and hours of caregiving assistance was .0005 (p = .997). These results with adult care home operators do not support the hypothesis, and they do not match the
findings in both family caregiving literature (George and Gwyther, 1986; Montgomery, et al., 1985; Robinson, 1983) and in nursing literature (Cronin-Stubbs and Rooks, 1985) which found that caregiving support is negatively correlated with level of stress.

**Perceived Benefits and Stress**

Two research questions were generated in regard to the relationship between perceived caregiving benefits and the level of perceived stress. The first question asked whether total perceived benefit was related to lowered levels of stress in adult care home operators. The second research question queried whether certain perceived benefits were more highly correlated with lower levels of stress in the home operators. Table 7 shows the frequency distribution in home operator responses to questions about the benefits of providing care, as well as data for the total benefits score attained by summing the scores for the four benefits included in the study.

The data in Table 7 present an interesting picture of the ways in which home operators perceive that their caregiving benefits them. For all benefits except the satisfaction of helping others, the spread of ratings was quite broad. When asked to rate the extent to which operating a home benefitted them financially, responses
Table 7. Perceived Benefits of Providing Care
Rated on a Scale from 0 (not at all) to 5 (a great deal)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Benefits</td>
<td>69</td>
<td>2.5</td>
<td>1.7</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Satisfaction of Helping Others</td>
<td>69</td>
<td>4.8</td>
<td>.5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Can Work at Home</td>
<td>68</td>
<td>4.3</td>
<td>1.2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Provides Companionship</td>
<td>69</td>
<td>3.8</td>
<td>1.5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total Benefits (sum of all scores)</td>
<td>68</td>
<td>15.4</td>
<td>3.0</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>

ranged from 0 (not at all) to 5 (a great deal). The mean rating was modest—2.5 on a scale of 0 to 5—indicating that operating an adult care home provides only perceived moderate financial benefit for most home operators. Home operators reported that running an adult care home benefitted them much more in terms of enabling them to work at home and providing companionship, rating these benefits with a mean of 4.3 and 3.8, respectively.

Home operators were extremely consistent in their high rating of the extent to which running a facility benefits them by giving them the satisfaction of helping others. The scores ranged from a low of only 3 to a high of 5, with a mean rating of 4.8. It is possible that the scoring for this item was inflated by a social desirability response,
with home operators perhaps feeling that a high rating was expected for this question. It is also possible that the majority of home operators enter this business because they get satisfaction from helping others, resulting in extremely high scores on this item.

Research question number four asked about the relationship between total perceived benefit and lowered stress, requiring a summing of the ratings made by home operators of each of the four potential areas in which caregiving had benefitted them: financially, giving them the satisfaction of helping others, enabling them to work at home, and providing companionship. These ratings were summed into a total benefits score.

Table 8 shows the results of a Pearson’s correlation between total benefits and stress. As the data show, no significant relationship was found to exist between the total benefits score and the level of perceived stress in the adult care home operator.
Table 8. Correlations of Perceived Benefits with Perceived Stress

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Financial Helping Benefits</th>
<th>Work at Home</th>
<th>Companion-ship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Benefits</td>
<td>.00</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Benefits</td>
<td>.19</td>
<td>.58**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Satisfaction of Helping Others</td>
<td>-.13</td>
<td>.41**</td>
<td>.11</td>
<td>1.00</td>
</tr>
<tr>
<td>Work at Home</td>
<td>.11</td>
<td>.68**</td>
<td>.13</td>
<td>.14</td>
</tr>
<tr>
<td>Companion-ship</td>
<td>-.25*</td>
<td>.64**</td>
<td>-.08</td>
<td>.30*</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01

The fifth research question was exploratory, questioning whether some of the perceived benefits were more highly correlated with lower stress levels than other benefits. Table 8 show that only one of the benefits in the study had a significant correlation with level of stress. A low, negative correlation of -.25 (p<.05) was found to exist between the perceived benefit of companionship and the level of stress felt. This finding indicates that a home operator's level of perceived stress decreased slightly the more the home operator believed that being a caregiver benefitted him or her with companionship.
In spite of the very high mean ratings which the satisfaction of helping others (4.8) and the ability to work at home (4.3), these benefits were not found to be significantly related to the level of perceived stress in home operators. Although these two factors were believed by home operators to be major benefits of their work, they did not impact the level of stress experienced by the home operators in that work. Although fewer home operators found the companionship of the work to be rewarding, those who did find it to be of great benefit perceived their work to be somewhat less stressful than did the other home operators.

**Resident Care Needs and Stress**

The sixth research question addressed in this study asked whether increased resident care needs were associated with higher levels of perceived stress. It was hypothesized that the level of combined resident care needs within a home would correlate positively with the level of stress experienced by that home operator.

Correlation with stress was calculated for the total of resident care needs per home. Correlations were also calculated using components of the care needs score, dividing it into physical care needs and behavioral care needs. Table 9 shows the frequency distributions for these different variables.
Table 9. Resident Care Needs

<table>
<thead>
<tr>
<th>Care Needs</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Care Needs</td>
<td>67</td>
<td>10.4</td>
<td>9.2</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>Physical Care Needs</td>
<td>67</td>
<td>37.0</td>
<td>18.3</td>
<td>9</td>
<td>82</td>
</tr>
<tr>
<td>Total Care Needs</td>
<td>67</td>
<td>47.1</td>
<td>24.1</td>
<td>11</td>
<td>112</td>
</tr>
</tbody>
</table>

Pearson’s correlations revealed that, as hypothesized, the level of resident care needs was significantly correlated with level of perceived stress. A low correlation of .29 (p<.02) was found to exist between the variables, indicating that level of stress increases as the total level of resident care needs increases.

Correlations between stress and the two components of resident care needs—behavioral care needs and physical care needs—indicate that it is the level of behavioral care needs that significantly impacts stress, and not the level of physical care needs. As shown in Table 10, a significant moderate correlation of .35 (p<.01) exists between stress and the level of resident behavioral care needs and problems, while no significant relationship exists between physical care needs and level of stress. These findings indicate that increases in the total sum of resident behavioral problems and care needs resulted in moderate increases in stress level for the home operators, while the sum of
physical care needs did not significantly impact the level of stress experienced by the operators.

Table 10. Correlations of Resident Care Needs and Perceived Stress


<table>
<thead>
<tr>
<th></th>
<th>Stress</th>
<th>Total Needs</th>
<th>Behavioral Needs</th>
<th>Physical Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Resident Care</td>
<td>.29*</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Care Needs</td>
<td>.35**</td>
<td>.78***</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Physical Care Needs</td>
<td>.22</td>
<td>.95***</td>
<td>.56***</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01  ***p<.001

Both the family caregiving literature (Herz et al., 1976; Robinson, 1983) and the nursing stress literature (Chiriboga and Bailey, 1986; Grout et al., 1981) record studies which support that physical, functional care needs are associated with increased levels of stress for these two types of caregivers. However, this finding did not hold true for adult care home operators. For the adult care home operator, it was the residents' total sum of behavioral needs and problems which significantly effected the level of perceived stress. Family caregiver studies (Herz et al., 1976; Hoenig and Hamilton, 1966) and nursing studies
(Cronin-Stubbs and Rooks, 1985) have also both found evidence that behavioral/psychiatric needs and problems are stressful to caregivers; these findings seem to relate most closely to the data obtained in interviews with the adult care home operators.

Several possibilities exist which may explain why behavioral care needs and not physical care needs impacted the level of stress in the adult care home operator. First, although the adult care home operator cares for multiple dependent adults, the extent of physical care needed by those residents differs qualitatively from the type of care provided by some family caregivers and by many nurses. The nursing stress studies which found that physical patient care correlated with stress (Chiriboga and Bailey, 1986; Grout et al., 1981) were done on medical-surgical nurses and nurses on intensive care units. These subjects were providing extensive skilled nursing care, while the adult care home operators by definition of law can provide only personal care services such as help with bathing, dressing and grooming. The family caregivers included in studies which found correlations between physical care and stress may also have required more extensive types of care than the adult care home operator would ever be called upon to provide. Physical and functional kinds of care needs may only impact level of perceived stress when the care is of a more
extensive or skilled nature.

A second explanation for this correlation may relate to the expectations of the adult care home operator. Adult care home operators choose to go into the business of caring for dependent adults. Adult care home operators go into caregiving with the expectation and acceptance of the necessity of providing physical care to their residents. Although home operators may expect to carry out physical caregiving tasks, they may not expect to have to cope with violent or bizarre resident behaviors. If home operators are not anticipating having to manage these kind of behavioral care problems, they may contribute more significantly to the stress that those caregivers experience.

Predictive Model for Stress in Adult Care Home Operators

Levels of perceived stress in adult care home operators are an area of concern because high stress is associated generally with impaired ability to function. If a home operator is highly stressed and his or her ability to provide care is compromised, the health and welfare of several vulnerable adults is immediately placed in jeopardy. As a result, it is important to develop an equation which can be used to predict the extent to which an individual home operator is experiencing stress. Such a predictive tool
could assist agencies which recruit, train, and license homes to identify potential high risk situations and to take subsequent action to minimize the stress experienced by the home operator.

At the outset of this study, it was hypothesized that nine variables would be significantly correlated with home operator stress: age, income, self-reported health, social supports, resident care needs, and four types of benefits from providing care. Pearson correlations of these variables with stress revealed that only three were significantly correlated with the dependent variable. Those three variables were age, resident care needs--both total care needs and behavioral care needs--and the benefit of companionship.

To assess the effectiveness of these variables as predictors of stress, they were utilized in a multiple regression analysis with the dependent variable of stress. Because total care needs scores and behavioral care needs scores were so highly intercorrelated (.78, \( p < .0001 \)), it was decided that only one of the scores should be used in the regression equation. Behavioral care needs was selected for inclusion, based on its stronger correlation with the dependent variable (.35, \( p < .01 \)). Age, behavioral care needs and companionship were all examined in their scatterplot form correlated with stress to ensure that the data were linear
and therefore suitable for multiple regression analysis.

Table 11 shows the regression of stress on age, behavioral care needs, and the benefit of companionship. The

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>St.Error B</th>
<th>Beta</th>
<th>Corr.</th>
<th>T</th>
<th>Signif.T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Needs</td>
<td>.2925</td>
<td>.0954</td>
<td>.3187</td>
<td>.3474</td>
<td>3.1</td>
<td>.0032</td>
</tr>
<tr>
<td>Companionship</td>
<td>-.9333</td>
<td>.5792</td>
<td>-.1700</td>
<td>-.2423</td>
<td>-1.6</td>
<td>.1121</td>
</tr>
<tr>
<td>Age</td>
<td>-.2824</td>
<td>.0772</td>
<td>-.3870</td>
<td>-.4438</td>
<td>-3.7</td>
<td>.0005</td>
</tr>
<tr>
<td>(Constant)</td>
<td>37.5391</td>
<td>4.5603</td>
<td></td>
<td></td>
<td>8.2</td>
<td>.00001</td>
</tr>
</tbody>
</table>

variables were entered simultaneously, since no theory base existed which would dictate a particular stepwise entering of the variables. As can be seen from the data in this table, home operator age had the largest effect on the level of perceived stress, with a Beta of -.3870. Behavioral care needs of residents follows closely with a Beta of .3187. The benefit of companionship was found to have a Beta of -.17.

The Multiple R for the regression of Stress on these three variables was .5689, providing an R Square of .3237. The adjusted R Square, adjusted for the population, was .2915 (F=10.05, p< .00001). The resulting equation for the prediction of stress among adult care home operators was
found to be the following:

\[ \text{Stress} = 37.5391 + .2925 \text{ resident behavioral care needs} - .9333 \text{ companionship benefit rating} - .2824 \text{ age of the home operator} \]

The variables in this equation accounted for just over 32\% of the variance in the level of stress in the operators in this study.

Although the rating of the companionship benefit was not statistically significant at an alpha level of < .05, it was included in the prediction equation. Multiple regression equations calculated with only age and behavioral care needs resulted in a Multiple R of .5439, an R Square of .2958, and an adjusted R Square of .2738. These findings indicate that, while the companionship benefit score was not significant in the regression analysis, it did add to the amount of variance explained and to the predictive value of the equation.

Residuals were calculated for the predicted Y value, as well as for each of the variables against which stress was regressed. The histogram of the standardized residual revealed no cases falling above 3.00. Scatterplots of residuals for the predicted Y and for age, behavioral care needs, and companionship benefit revealed that the residuals were normally and randomly distributed.
Experiences Considered Stressful by Home Operators

The final research question posed by this research asked what experiences adult care home operators consider to be stress producing. Data were gathered by asking home operators the open-ended question "What do you find to be the most stressful aspects of operating an adult care home?" This open-ended format was utilized to generate any categories of caregiving stressors that might be unique to home operators, and which could be included as quantitative variables in future research.

Table 12 shows the categories of responses which home operators provided to this question. Six areas of stress were identified: factors relating to care for/interactions with residents, resident behaviors/confusion, interactions with others, restrictions on the home operators life, financial/business issues, and personal feelings/experiences. Over 8% (6) of home operators interviewed indicated that there was nothing about operating an adult care home which they considered stressful (the percentages in the table do not total to 100% because most home operators identified more than one stressful aspect of operating a home).

The category of experiences most commonly identified as stressful was that of caregiving for/interacting with the residents in the adult care home. Almost 32% of operators surveyed reported experiencing this broad array of stressors
Table 12. Experiences Considered Stressful by Home Operators

<table>
<thead>
<tr>
<th>Experience</th>
<th>%</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Caregiving For/Interaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Residents: Total</td>
<td>31.9%</td>
<td>(22)</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>5.8</td>
<td>(4)</td>
</tr>
<tr>
<td>When Resident is Sick/Emergency</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Lack of Resident Activity Programs</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Finding Caregiving Help</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Mix of Resident Personalities</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Physical Exertion of Caregiving</td>
<td>2.9</td>
<td>(2)</td>
</tr>
<tr>
<td>Combining Residents into Family Life</td>
<td>2.9</td>
<td>(2)</td>
</tr>
<tr>
<td>Loss of a Resident</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Emotional Involvement with Residents</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>II. Resident Behaviors/Confusion:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30.4%</td>
<td>(21)</td>
</tr>
<tr>
<td>Resident Behaviors</td>
<td>26.0</td>
<td>(18)</td>
</tr>
<tr>
<td>Confusion</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td><strong>III. Interaction with Others:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>26.1%</td>
<td>(18)</td>
</tr>
<tr>
<td>Family Insensitivity/Problems</td>
<td>18.8</td>
<td>(13)</td>
</tr>
<tr>
<td>Problems with Social Workers/Other Professionals</td>
<td>7.2</td>
<td>(5)</td>
</tr>
<tr>
<td><strong>IV. Restrictions on Own Life:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21.7%</td>
<td>(15)</td>
</tr>
<tr>
<td>Confinement/Cannot Get Away</td>
<td>7.2</td>
<td>(5)</td>
</tr>
<tr>
<td>Lack of Substitute Caregivers</td>
<td>4.3</td>
<td>(5)</td>
</tr>
<tr>
<td>Constancy/No Time for Self</td>
<td>7.2</td>
<td>(5)</td>
</tr>
<tr>
<td>Lack of Privacy</td>
<td>2.9</td>
<td>(2)</td>
</tr>
<tr>
<td><strong>V. Financial/Business Operation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>17.4%</td>
<td>(12)</td>
</tr>
<tr>
<td>Lack of Money</td>
<td>7.2</td>
<td>(5)</td>
</tr>
<tr>
<td>Non-Payment</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Placements/Staying Full</td>
<td>2.9</td>
<td>(2)</td>
</tr>
<tr>
<td>Regulation</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Maintaining the Home</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>VI. Personal Feelings/Experiences:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7.2%</td>
<td>(5)</td>
</tr>
<tr>
<td>Personal Life Problems</td>
<td>4.3</td>
<td>(3)</td>
</tr>
<tr>
<td>Seeing What Happens to the Aged</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td>Unrealistic Expectations</td>
<td>1.4</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>VII. Nothing:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8.7%</td>
<td>(6)</td>
</tr>
</tbody>
</table>

which included the constancy of meal preparation, when residents are sick or have a medical emergency, a lack of
adjunct activities and programs for residents to keep involved, difficulties finding caregiving help, the mix of various resident personalities within the home, and emotional involvement with the residents.

Resident behaviors/confusion comprised the second most frequently cited category of stressors, although resident behavior problems was the single most commonly identified stressor (26%) for the adult care home operators interviewed. The operators talked about a variety of resident behavior problems, including refusals to bathe, stealing from other residents, wandering, depression, manipulativeness, and unreasonable demands. These data support the finding from the use of the resident care needs measure that resident behavior problems are significantly negatively correlated with the level of perceived stress in the home operator. Several home operators interviewed also identified that dealing with resident confusion and the resulting demands for supervision and repetition of information was a stressor.

The next most frequently identified source of stressors for home operators was the category of difficult interactions with others outside of the care home itself, in which 26.1% of those interviewed identified having stresses. Almost 19% cited difficulties with families, primarily relating to family visitation of residents. The specific problems identified included families not calling before coming to
visit, families coming at times other than during visiting hours, families who upset the residents and home operator during their visits, and families who will not visit their relatives at all. Home operators also talked about the families’ demands upon them, including unreasonable demands for levels of personal care and attention that are impossible to achieve when looking after the needs of multiple residents. Additionally, home operators cited family dishonesty when placing residents into the home, with families not giving accurate information about resident care needs and behavior problems.

Within this same category of interaction with others outside the home, over 7% of operators identified problems they were experiencing with professionals connected with their residents such as social workers and physicians. They spoke about several types of problems, including the difficulty in accessing these professionals when a resident needs help, and the slowness with which they act when they did respond to a need. They indicated that this lack of adequate supportive help from these professionals made their caregiving jobs more difficult and thus more stressful.

Although more than 26% of the home operators specified that interactions with family or with some professional were stressful, analysis of the responses to questions about stress from family members and agencies in the original
stress scale revealed that those items did not contribute to the reliability of the overall stress scale. As a result, the two items in the original scale which dealt with families and agencies were dropped from the final version of the scale which was used for the quantitative data analysis.

Almost 22% of the home operators interviewed identified the restrictions which caregiving places on them as stressful. Within this category, a number of home operators discussed the difficulties in finding substitute caregivers and being able to get away. One operator stated that she had not had a two week vacation in over nine years. Trips had been scheduled, but they always had to be cancelled because of some problem in the home. Another spoke of having to weigh everything she does outside the home, asking if she can find the time to go and whether she can find a substitute home operator to provide care while she is out. Several stated that they cannot find people who are willing to or capable of serving as substitute caregivers; others said that they could not afford to pay a substitute and so they are unable to get away from the home.

Also in the category of restrictiveness, home operators spoke eloquently about the stress which the constancy of the work imposes upon them. One operator stated that the constancy of the cooking, cleaning, and supervision is a never-ending cycle, and she likened it to being "like a
squirrel on a wheel". Another described it as a 24-hour a day job. She commented that other businesses have three shifts going, but that "we're here 24 hours...we're the only ones tending to these people 365 days a year". Those home operators who identified the inability to get away and who felt constrained by the constancy of the work spoke with tremendous passion about the stressfulness of these experiences. This strength of emotion was not equalled in any of the other comments which operators made during their interviews, indicating that these experiences may, when perceived as stressors, create more distress for the home operator than do other perceived stressors.

Financial and business problems were identified as stressful by 17.4% of the home operators. Financial problems were most commonly cited, including a lack of money from taking low-income residents and problems with non-payment by residents for the care provided. Problems with complying with regulations and maintaining the physical aspects of the home were identified by other home operators as stressful.

Several home operators identified that their work as home operators was made more stressful because of personal feelings or experiences. Three home operators mentioned other life events as being stressful, including dealing with their teenagers, going through a pregnancy, and other family demands. Others discussed their own feelings as being
stressful, including concern over seeing what happens to the elderly and having unrealistic expectations for the improvement that residents should show once in the home.

Interestingly, almost 9% of home operators stated that they did not find any aspect of their work to be stressful. Almost all of these home operators stated that "nothing is stressful right now", indicating that they had had stressing experiences in the past. It seemed that these home operators were responding to the question in terms of their feelings at the particular moment when they were interviewed, as opposed to considering the stresses which they may have experienced in the past or over time.

Positive Experiences of Home Operators

To obtain a more complete understanding of why adult care home operators choose to continue providing care in their homes, the subjects interviewed for this study were asked to respond to the open-ended question "What do you feel are the most beneficial, enjoyable, or rewarding aspects of operating an adult care home?". Rather than focusing on the distressing elements of being a home operator, this question gave home operators the opportunity to express the positive elements of caregiving as they perceived them.

Table 13 shows the responses provided by home operators in response to this question (percentages do not sum to 100%
Table 13. Aspects of Operating a Home Considered Beneficial by Caregivers

<table>
<thead>
<tr>
<th>Beneficial Aspect of Operating a Home</th>
<th>%</th>
<th>( N )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping/Caring for Those in Need</td>
<td>36.2%</td>
<td>( 25 )</td>
</tr>
<tr>
<td>Seeing Growth/Improving Health or Happiness in Residents</td>
<td>30.4</td>
<td>( 21 )</td>
</tr>
<tr>
<td>Being With/Loving the Residents</td>
<td>26.1</td>
<td>( 18 )</td>
</tr>
<tr>
<td>Receiving Praise/Appreciation for Your Work</td>
<td>15.9</td>
<td>( 11 )</td>
</tr>
<tr>
<td>Providing a Quality Service</td>
<td>14.5</td>
<td>( 10 )</td>
</tr>
<tr>
<td>Enables Caregiver to Work at Home</td>
<td>11.6</td>
<td>( 8 )</td>
</tr>
<tr>
<td>Provides Companionship to the Home Operator</td>
<td>10.1</td>
<td>( 7 )</td>
</tr>
<tr>
<td>Is Financially Rewarding</td>
<td>8.7</td>
<td>( 6 )</td>
</tr>
<tr>
<td>Providing a Needed Service</td>
<td>7.2</td>
<td>( 5 )</td>
</tr>
<tr>
<td>It is Educational</td>
<td>5.8</td>
<td>( 4 )</td>
</tr>
<tr>
<td>Fulfills Religious Beliefs</td>
<td>2.9</td>
<td>( 2 )</td>
</tr>
</tbody>
</table>

because several home operators gave multiple responses).

As this table shows, over 36% of home operators surveyed responded that helping or caring for those in need was one of the most rewarding aspects of operating an adult care home. One home operator stated, "I enjoy being strong enough to help people in need". Another response was, "It is good to take care of people who need it". Providing this needed help seemed to provide great fulfillment for some of the home operators. As one operator phrased it, "Without these people, I’d be nothing. If I can’t help people, there’s no
point in being here."

The second most commonly expressed area of benefit was seeing growth and increased happiness and health on the part of residents. Over 30% of the home operators said that they found it rewarding to see their residents come into their homes and change for the better as a result of the care in that home. Some home operators expressed surprise at the changes, such as the home operator who stated that it was rewarding "seeing the people improve. I didn’t expect that anyone would get better". Others spoke in terms of expecting residents to improve and even move on to independence, such as the operators who said it was rewarding to "see the end results—seeing someone go to live in their own apartment", and "when you see someone leave and be able to live on their own--someone who really achieved a lot".

Sometimes the changes cited were not improvements in health or functioning, but were emotional improvements. As one operator commented, it was rewarding for her when "they have been unhappy, and then they come here and were happier". Another commented that it had been rewarding to "see the resident crawl out of her shell and become a different person".

The next most common area of benefit identified by home operators was the enjoyment of being with the residents and the pleasure of having affectionate relationships with them.
(26.1%). One operator stated that what is rewarding to her is "relating to the boys [her residents]. Makes my day for me". Others had similar comments: "having the people here is a joy"; "I like working with the people--it is a joy to me"; and "they are a lot of fun. They laugh a lot. They call me 'our sweetheart' and 'angel'. I just love them all". One home operator stated, "They are just like a family to me. We cry together, we laugh together". Many of these same operators had identified that it was rewarding to be providing a service that the residents needed, but they also emphasized that their relationships with their residents were also a source of great happiness for them. The importance that having an affectionate relationship with residents holds for many home operators may explain in part why resident behavior problems were a significant stressor for these caregivers. Resident behavior problems such as being withdrawn, depressed, angry, or upset would pose a substantial barrier to the development of affectionate and positive relationships with those residents.

Almost 16% of home operators indicated that the appreciation and gratitude expressed by the residents for their caregiving was a source of reward for them. Home operators commented that it was rewarding "being appreciated for meals or bathing. They are so appreciative". Others stated, "When you do something, they appreciate it"; and
"getting the praise is good".

These sentiments differ in focus from the responses by another 14.5% of the operators, who stated that it was rewarding to them to provide a high quality service. Whereas the above-mentioned home operators found benefit in the expressions of gratitude made by the residents, these home operators found reward simply from knowing that they were providing good care to their residents. As one home operator put it, it was rewarding "just knowing these men have a good place to live, are clean, and well cared for". Another stated, "I provide good care, and it's the best they could receive". Although these comments are similar to those made by home operators who found it satisfying to be helping people in need, these responses emphasize the satisfaction attained from the quality of the service provided, as opposed to the emphasis in the other responses on the rewards experienced from caring for people who really need the help.

The benefit of being able to work at home was identified as important by 11.6% of the home operators. Several stated that it enabled them to be at home to care for their own children or for their grandchildren. As one operator put it, operating an adult care home enables her to "have my cake and eat it too. I can be here for the family while I do the work I love to do". Others said that they just enjoyed being able to spend time at home, since that is where they are
happiest.

Other subjects found the companionship to be a benefit of operating an adult care home. For some, it prevents loneliness, as for the operator who said "I was lonely and they were, too. Now we're all together". For others, having residents provided persons with whom to engage in enjoyable activities. One operator cited that she enjoys "...the company. I love it. I take them to Bingo"; another stated that some of her residents go to church with her, and that she likes it when they participate in the worship service with her”. Whereas many of the operators found it rewarding to provide rather one-directional service to others, these operators found satisfaction and benefit from the mutually rewarding companionship that the care arrangement provided.

Financial benefits were cited by only 8.7% of the home operators. This suggests that, although operating an adult care home is a business, the primary benefits received by adult care home operators are not financial. Among those who identified financial rewards, most also specified additional rewards of caregiving such as enjoying the people and providing care to those in need. Only one subject stated that the financial reward was the only benefit of operating a home.

Several home operators (7.2%) said that they received satisfaction from providing a needed service. These operators
were not simply saying that they enjoyed helping others in need; rather, they were viewing the importance of their work from a societal perspective. They referred to the satisfaction received from meeting a need within this society for this type of reasonably-priced, community-based long-term care. Instead of considering their work only from a very individual perspective, as did most of the subjects, these home operators were receiving satisfaction from the role that they were playing in the long-term care continuum.

Some operators (5.8%) found their work to be rewarding because it was educational. They referred to the informative nature of working with a variety of different people with different backgrounds. Other operators (2.9%) stated that their caregiving work provided satisfaction because it enabled them to act on their religious beliefs. As one home operator said, "it's fulfilling to me in my religious beliefs, knowing I'm sharing my home and myself with them".

These responses indicate that, although many home operators perceived their caregiving as stressful, they also perceived that many aspects of that work were rewarding and satisfying. Some of those rewards were based on the somewhat intangible satisfactions of helping people in need, providing a good service, and being an important part of the long-term care continuum. Others rewards were more tangible: praise, affection, companionship, money, and being able to work at
home. No subject interviewed perceived that operating an adult care home had no aspects which were satisfying or rewarding.

Policy and Program Needs Identified by Home Operators

To identify programs and policies which might help to support adult care home operators and reduce the level of stress which they experience, subjects in the study were asked "What services, programs, or laws would make your job as an adult care home operators easier and/or less stressful?". The responses to this question are shown in Table 14 (percentages do not total 100% since some home operators gave more than one response).

The most frequently identified need among home operators (27.5%) was the need for financial assistance. Almost 19% of the subjects stated that they needed additional money, either coming directly to them or a supplement to resident incomes which would result in an increase payment rate for care. Thirteen percent of the home operators specified that they could benefit from the receipt of in-kind goods and services, including food from food banks, meals for residents, clothing for residents, and free health care services. It seems that, although some home operators believed that they benefitted financially from providing care, more home operators felt that they needed assistance
financially to do their caregiving work.

Table 14. Programs/Policies Needed by Home Operators

<table>
<thead>
<tr>
<th>Program/Policy/Service</th>
<th>%</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Financial Assistance: Total</td>
<td>27.5%</td>
<td>(19)</td>
</tr>
<tr>
<td>Additional Money</td>
<td>18.8</td>
<td>(13)</td>
</tr>
<tr>
<td>In-Kind Goods and Services</td>
<td>13.0</td>
<td>(9)</td>
</tr>
<tr>
<td>II. Programs for Residents: Total</td>
<td>17.4%</td>
<td>(12)</td>
</tr>
<tr>
<td>Day Programs</td>
<td>14.5</td>
<td>(10)</td>
</tr>
<tr>
<td>Special Programs for Young Residents</td>
<td>5.8</td>
<td>(4)</td>
</tr>
<tr>
<td>III. Licensing/Clearer or Tighter Regulations</td>
<td>11.6%</td>
<td>(8)</td>
</tr>
<tr>
<td>IV. Training/Technical Assistance</td>
<td>11.6%</td>
<td>(8)</td>
</tr>
<tr>
<td>V. Services for Residents</td>
<td>8.7%</td>
<td>(6)</td>
</tr>
<tr>
<td>VI. Substitute Caregivers</td>
<td>5.8%</td>
<td>(4)</td>
</tr>
<tr>
<td>VII. Support/Counseling</td>
<td>5.8%</td>
<td>(4)</td>
</tr>
<tr>
<td>VIII. Services for Home Operators</td>
<td>5.8%</td>
<td>(4)</td>
</tr>
<tr>
<td>IX. Placements</td>
<td>2.9%</td>
<td>(2)</td>
</tr>
</tbody>
</table>

The second most commonly identified service need among home operators was for programs for residents. Over 17% of subjects stated that their residents could benefit from the stimulation and socialization of recreation, activity, or training programs. One-third of those operators who identified the need for activities for residents added that transportation to such programs would be necessary, stating that they cannot leave some of their residents while they
transport others residents. One third of the operators who said that resident programs were needed also specified the need for special programs for younger residents. They explained that most activity opportunities in their areas were available only to senior citizens, leaving the younger residents without the benefits of such programs.

Somewhat surprisingly, several home operators stated that they wanted clearer and tighter regulations for adult care homes. At the time the interviews for this research was conducted, Ohio law required that only a few types of adult care homes be licensed. The rest were operating without any legislative guidance or standards. One home operator stated that she needed "clearer guidelines on how to run a family home. If there are no laws, how can they [agencies] tell you you're doing it wrong. You need directions. It's like a cake—you need directions to do it right". Another home operator said that she wanted licensing laws to be passed so that the home could be regulated and bad homes could be closed, thereby stopping the "bad press" that all homes were getting from those few bad homes.

Almost 12% of the study subjects answered this question by saying that they needed additional education and technical assistance. In this case also, the home operators indicated that they wanted guidance to ensure that they were doing their jobs correctly. One suggested having someone come in
occasionally to make suggestions. Home operators also indicated a desire to know more about the benefits and services to which residents were entitled.

Several home operators (8.7%) discussed various types of services for residents which they said would make their caregiving job easier and less stressful. Specific services mentioned were friendly visitors, regular in-home physicals, counselors, hair dressing, homemaker assistance, and a translator for a resident who speaks no English.

Almost 6% of home operators also identified the desire for additional services for themselves, including help with menu planning, handicap stickers for their cars, available caregiving help, and assistance with caregiving tasks for a physically disabled home operator. Another 5.8% of home operators said they needed help finding substitute caregivers for when they are away from the home. Close to 3% stated the need for more placements of residents into their facilities. A number of the caregivers interviewed (5.8%) identified that it would be helpful to them to receive counseling or to attend a peer support group to deal with the stresses of the job. One subject recommended having a counseling system for home operators staffed by people who have been adult care home operators.
CHAPTER V.

DIMENSIONAL ANALYSIS OF ADULT CARE HOME

OPERATOR STRESS SCALE

The scale developed for use in this study was based largely upon Robinson's (1983) uni-dimensional scale of overall burden. A uni-dimensional scale was selected for use in this research because stress had never before been measured in adult care home operators, and it was not known whether stress was multi-dimensional or uni-dimensional. It was decided that a uni-dimensional scale should be utilized which could then be analyzed for dimensional characteristics using factor analysis.

A principal components analysis was conducted using orthogonal Varimax rotation on the eleven items comprising the final version of the Adult Care Home Operator Stress Scale. Each item ranged from 1 (rarely or never) to 5 (most of the time). For this factor analysis, the Kaiser-Meyer-Olkin measure of sampling adequacy was .81. The Bartlett test of sphericity yielded a score of 290.61, which had a significance of <.000001. These results indicated that the data were appropriate for the factor analytic procedures.

Three interpretable factors, each containing different high-loading items, were identified in the analysis. These three factors accounted for 50.5% of the variance in the data.
set. Table 15 shows the items in each factor and the factor loading for each item.

The first factor identified has been entitled Lifestyle Changes, because the scale items loading on this factor related to changes in lifestyle experienced by the subjects as the result of operating an adult care home: confinement, inconvenience, changes in personal plans, changes in family life, and the upset of some resident behaviors. Factor 1 accounted for 38.7% of the variance in the data set.

The second factor accounted for an additional 6.7% of the variance in the data. The items loading highly on this second factor all related to tangible strains faced by the adult care home operator, including financial strain, being completely overwhelmed, the strain of competing demands on their time, and physical strains of caregiving tasks.

The third factor in this analysis included only two items, both of which related to emotional stresses accompanying the home operator's caregiving activities. One item addressed the upset of seeing residents decline over time, and the other asked about the emotional adjustments that occur when operating a home. This third factor accounted for the final 5.1% of the total 50.5% variance explained in the data set.

Herz, et.al. (1976), Hoenig and Hamilton (1967), Montgomery et.al. (1985), Niederehe and Fruge (1984), and
Table 15. Adult Care Home Operator Stress Scale  
(Mean=21.75; SD = 8.4)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1: Lifestyle Changes</td>
<td></td>
</tr>
<tr>
<td>1. How often do you find that it is confining?</td>
<td>.75</td>
</tr>
<tr>
<td>2. How often do you find that it is inconvenient?</td>
<td>.74</td>
</tr>
<tr>
<td>3. How often do you have to make changes in your personal plans?</td>
<td>.63</td>
</tr>
<tr>
<td>4. How often do you find that you have to make family adjustments?</td>
<td>.58</td>
</tr>
<tr>
<td>5. How often do you find that some resident behavior is upsetting?</td>
<td>.57</td>
</tr>
<tr>
<td>Factor 2: Strains</td>
<td></td>
</tr>
<tr>
<td>1. How often do you find it is a financial strain?</td>
<td>.63</td>
</tr>
<tr>
<td>2. How often do you feel completely overwhelmed?</td>
<td>.58</td>
</tr>
<tr>
<td>3. How often do you find that you have other demands on your time?</td>
<td>.56</td>
</tr>
<tr>
<td>4. How often do you find that it is a physical strain?</td>
<td>.40</td>
</tr>
<tr>
<td>Factor 3: Emotional Stress</td>
<td></td>
</tr>
<tr>
<td>1. How often do you find that it is upsetting to see residents have physical and emotional declines?</td>
<td>.62</td>
</tr>
<tr>
<td>2. How often do you find yourself making emotional adjustments?</td>
<td>.61</td>
</tr>
</tbody>
</table>

Thompson and Doll (1982) have all conducted studies which identify two primary dimensions of caregiver stress: objective burden and subjective burden. They have defined
objective burden as the ways in which caregiving interferes with the caregiver's life, while subjective burden is identified as those feelings of stress which a caregiver may have.

The factors identified in analysis of the Adult Care Home Operator Stress Scale fit conceptually into these two dimensions, but they provide an additional nuance of understanding by providing more than just two factors. Factor 1 of the Stress Scale--lifestyle changes--and Factor 2--tangible strains--both fit within the broader concept of objective burden. Both describe actual impacts that caregiving is having upon the life of the home operator. Yet the factor analysis on the home operator Stress Scale indicated that, at least for adult care home operators, the general category of objective burden may consist of several different factors. One type of impact on home operators was the change in lifestyle; the other type of impact was tangible stresses such as financial strain and physical strain. Factor 3 of the Stress Scale, which had items relating to home operator emotions, supports the concept of a factor relating to emotions of stress.

Other family caregiver researchers have considered caregiver stress as having multiple dimensions. Both Cantor (1983) and Stephens and Christianson (1986) have examined family caregiver stress along the dimensions of emotional
strain, physical strain, and financial strain, as well as focusing on caregiver lifestyle changes as an element of stress experienced. George and Gwyther (1986) researched caregiver stress along dimensions of physical health, mental health, finances, and social life. These findings more closely parallel the factor analytic findings of this Stress Scale analysis, separating elements which could be considered part of the concept of objective burden. These researchers identified a unique dimension of lifestyle change, as did this analysis. They also identified dimensions of financial strain and physical strain, which in this analysis loaded onto the same general factor relating to tangible strains in the home operator’s life.

Factor analysis of Novak’s and Guest’s (1989) 24-item measure of family caregiver burden has identified five factors relating to the level of stress experienced by the caregiver. Those five factors are time-dependence burden, or restrictions on the caregiver’s time; developmental burden, or feelings of being off schedule in social development as compared to peers; physical burden; social burden, or caregiver feelings of role conflict; and emotional burden. These factors provide further division and specification of the factor which factor analysis of the Stress Scale identified as lifestyle changes. Time-dependence burden, developmental burden, and social burden
were comprised of items comparable to those items which loaded on Factor 1 of the Adult Care Home Operator Stress Scale.
CHAPTER VI.

SUMMARY AND DISCUSSION

Summary of Findings

The results from interviews with 69 adult care home operators revealed that these caregivers did experience varying levels of stress in their work, and that some home operators reported relatively high levels of stress. Several key factors were identified as having a significant impact on the level of stress experienced: home operator age, resident behavior problems, and the caregiver’s belief that operating a home provides them with the benefit of companionship. Multiple regression analysis revealed that these three variables accounted for almost 30% of the variance in perceived stress levels. Regression analysis also identified a prediction equation which can be used to identify home operators or configurations of residents which are more likely to result in higher stress for the caregiver.

Interestingly, few of the hypotheses generated from examination of the family caregiving and nursing literature were supported by the findings of this research. Caregiver factors of self-reported health and income were found to have no significant correlation with level of perceived stress. Amount of social support in providing care was also found to have no correlation with stress. Only one of the four identified benefits of operating a home was correlated with
the home operator's stress level.

The responses to the three open-ended questions reveal the complexity and variety of the stressors which home operators experience. Caregiving tasks were most often identified as being stressful, with a wide variety of specific tasks being mentioned. The single most frequently identified stressor was resident behavior that is difficult to manage. The operators also specified that interactions with family members were stressful, as were social workers and other professionals serving the residents. Several also stated that the restrictions which operating a home posed on their lives were stressful, as were financial and business problems.

In spite of the many stressors identified, the home operators spoke enthusiastically about the many benefits which they believe they receive from running an adult care facility. The most frequently cited benefits were helping/caring for those in need, seeing the growth and improvement in residents after they move in, and being with/loving the residents. Other common responses included receiving praise, providing a quality service, being able to work at home, and receiving companionship. A number of home operators also specified that they were providing a needed service, it is educational, and it fulfills their religious beliefs. Only six of the 69 subjects said that operating a
home was financially rewarding.

When asked what services would make their jobs easier or would reduce their stress, the home operators responded with a number of possibilities. Financial assistance was most commonly mentioned, followed by programs for residents, increased regulatory clarity, and training for themselves. Other suggestions included services for residents, substitute caregivers, and services for home operators, including support or counseling and placements.

Limitations

The generalizability of the results of this study is limited by two primary factors. First, the sample was restricted to only those adult care homes which were the operator's own home, and where he or she was the primary caregiver with no hired caregiving assistance. While the small family home is the most common type of adult care home throughout the country, there are also many adult care homes which are larger and which have hired staff. The sample is also limited to homes of the type known to the Nursing Home Ombudsman Program in Cleveland. These restrictions imposed on the sample result in the findings being generalizable only to adult care homes of the type included in the study sample.

A second factor which could impact the generalizability of the results is the difference across states in the types
of regulations for adult care homes and the extent to which regulations are enforced. A tremendous amount of variety exists across states regarding regulation and oversight of adult care homes, and these differences in regulation may result in differing levels of stress for adult care home operators. At the time these data were gathered, few regulatory standards existed for adult care homes in Ohio, and most facilities were not required to be licensed. The home operators in this study stated that clearer and more stringent requirements would make their jobs easier and would reduce their stress. In other states where regulations are more comprehensive and more strictly enforced, home operators may not have perceived a need for clearer laws.

Methodological Implications

The data from this research lead to a number of methodological implications and considerations for future study. The first important implication is the success with which two new measures were used in research with adult care home operators. The Adult Care Home Operator Stress Scale, which was modified from an existing family caregiver scale, was found to be a reliable (Cronbach’s alpha=.86), brief scale which was effectively used with this population. Data from use of this scale also permitted factor analysis which revealed the multi-dimensional nature of stress in adult care
home operators. This scale should be valuable in future research done with adult care home operators.

A second unique measure used in this research on adult care home operators was the modified Menninger acuity measure. This measure successfully provided a method for assessing the physical and behavioral care needs and problems of multiple impaired adults living in an adult care facility. Measures used in family caregiving studies focus on only one dependent individual.

Another significant methodological implication of this research relates to the way in which some of the variables were operationalized. Both income and social support as operationalized for this research were found to not be correlated with stress. However, the results obtained through the posing of open-ended questions suggest that the variables relating to finances and social support are related to stress in adult care home operators. It is possible that these two variables may need to be measured differently in the adult care home operators than they would be in a family caregiver or a nurse.

Although neither monthly income or monthly charge for care was found to be correlated with level of stress, financial concerns were evident in the responses when operators were asked what services, programs or policies would benefit them and reduce their stress. The most frequent
response (27.5%) was the need for financial assistance, either as a monetary supplement or as in-kind goods and services. This strong response indicates that financial concerns are prevalent for home operators, and that they may correlate with the operator's stress. Further study should be done using a subjective measure of the home operator's feelings about the adequacy of the income which they are receiving, rather than using objective measures of income as was done in this research. A subjective measure may more accurately operationalize the financial area of concern than did the objective measures, and may result in a correlation with level of stress.

Similarly, the operationalization for social support in this study may have missed the most relevant connection between stress and social support. For the purposes of this research, social support was operationalized as number of hours per week of caregiving assistance that the home operator received. This variable was not significantly correlated with stress. Since the data revealed that functional caregiving tasks were not correlated with level of perceived stress, it is not surprising that the amount of help with caregiving was not related to stress. Because a number of the home operators talked about the constancy of the work, about their stress in not being able to get away, and about their inability to find adequate substitute
caregivers, the variable social support might have better been operationalized as the amount of substitute caregiving help available, or the number of hours per week that the home operator can be away from the home.

The variable self-reported health was also found to have no significant relationship with the level of stress felt by the home operators. On the question about health, most home operators (87%) identified their health as good or very good. Only 4.3% said their health was not so good, and none rated their health as bad. It is possible that adult care home operators close their homes and discontinue providing care once they perceive that they are in bad health. This would explain why so little poor health was reported by the home operators; it may also explain why no correlation was found between self-reported health and stress. Longitudinal research on the caregiving career of adult care home operators would reveal how and when home operators choose to leave caregiving, and may indicate whether these operators do indeed cease to provide care when their own health declines.

Practice Implications

The data suggest a number of practice implications for agencies working with adult care homes and adult care home residents. One implication relates to the functions of recruiting and monitoring adult care home operators.
Agencies are often responsible for recruiting home operators, training them, and providing ongoing monitoring of their performance. As they recruit adult care home operators, agency personnel should consider that age was found to be the most significant variable in explaining variance in perceived stress, and that younger operators who had been in business a shorter length of time were more likely to have high levels of stress. Agencies may want to monitor young, less experienced operators more closely, and may want to provide an extra measure of encouragement, support, and guidance to the younger home operators. It may be helpful for agencies to meet more frequently with younger and newer operators to answer questions and to provide support.

Licensing systems and agencies working with homes need to also consider that home operators identified that additional training and technical assistance would make their jobs easier and would reduce their levels of stress. It would seem that young and inexperienced home operators especially would benefit from educational programs and technical assistance tailored specifically to the problems and interests of adult care home operators. Such educational programming would not only have the potential to reduce the home operators' stress, but that it would also have the important benefit of improving the quality of care received by the vulnerable residents of these facilities.
Agencies and hospitals involved in placing residents into adult care facilities also need to consider the finding that the overall extent of resident behavioral care needs and problems was significantly related to the stress experienced by the adult care home operators. When placements are being arranged into adult care homes, consideration should be given not only to the behavioral needs and/or problems of the resident being placed, but also to the behavioral needs/problems of residents who are already residing in the home. Attention needs to be given to the total level of behavioral difficulty present in a home—and the concomitant demand and stress placed on the home operator—before a new resident is placed into that facility.

The data also suggest that social service agencies should examine ways in which day programs could be offered to the residents of adult care homes, including the younger residents. Senior centers may want to consider ways to identify adult care residents in their areas which could benefit from the socialization and stimulation of their activities and meals programs. Other systems or agencies such as mental health centers could examine the possibility of establishing day programs for young emotionally impaired residents which could promote their independence, improve their self-esteem, and possibly help them to develop new skills or interests.
The findings also present valuable guidance to the social workers, physicians, and other professionals who provide services to adult care home residents. Several home operators indicated frustration at being unable to access needed services for residents. Inability to access these services doubly jeopardizes the adult care resident: first, the resident suffers because he or she is not receiving a needed service, and, second, the resident’s care may be impacted because the home operator is stressed over the difficulty in securing assistance. These residents are vulnerable adults who cannot afford this dual jeopardy. Professionals need to be attentive to the needs of both the residents and the home operators.

Policy Implications

The results of this research also suggest a variety of important policy implications. One primary policy initiative indicated by the data is the need for supplemental funding for adult care home operators. Although the objective measures of income did not reveal a correlation with stress, financial supplementation was the most commonly identified need among home operators in the sample. The home operators themselves had several suggestions as to how financial support could be given, including increasing residents' general monthly income, making extra payments directly to the
home operators, or providing in-kind goods and services such as food and clothing. Home operators especially called for an examination of the adequacy of the Supplemental Security Income level, stating that the monthly amount paid by low income residents was not enabling them to meet expenses.

Another policy initiative indicated by the data is the creation of clearer, tighter regulations for adult care homes. The home operators were responding to Ohio’s general lack of regulation, but their sincere interest in having clear guidelines to follow is informative to policy makers in all states and on the federal level. Their statements indicate that adult care home operators want structure and guidance from regulations so that they know they are doing their jobs adequately and as expected. Regulations for adult care homes need to be thought of as important because they provide guidelines for the well-intentioned operator, and not just because they provide controls against operators who are not attempting to provide adequate care.

Home operators also indicated a desire for technical assistance and training to assist them in their caregiving job. The data suggest a dual role for such training. First, technical assistance programs could help to meet the home operator need for greater clarity and understanding of regulatory guidelines. Second, education programs could assist in reducing home operator stress by improving
knowledge of caregiving and resources and by improving the confidence of the home operator. Specific education in meeting behavioral needs and in managing behavior problems might be especially effective in reducing the stress of home operators. The importance of technical assistance and education suggests that state or federal policies mandating the availability of such services and requiring the participation of home operators should be established.

The data also indicate the need to examine policy alternatives to provide adult care home operators with opportunities to have time away from the constancy of their work. Financial supplementation to hire substitute caregivers would meet this need to some extent, but home operators indicated difficulties in even finding willing and capable substitute caregivers. Consideration may need to be given to the establishment of pools of substitute caregivers in addition to the provision of financial support to help the home operator afford to pay an alternate care provider.

Finally, the results of this study suggest that it may be worthwhile to consider a centralized placement program for adult care homes. Having all placements channelled to homes through one agency or system may enable that single source to more effectively monitor the behavioral care demands being placed on any individual facility, and so may prevent exceptionally stressful combinations of residents from being
placed in one home. Having a single placement source may also reduce the number of different social workers and agencies with which a home operator would have to work, possibly also reducing the operator’s level of perceived stress.

**Theory Implications**

The findings from this research provide support for several components of the interactive model of stress theory on which the study was based. The model presumes that the interactive process begins when a stressor is introduced to an organism; the individual experiencing the stressor then appraises the extent to which the situation is stressful. This appraisal process is impacted by characteristics of the person experiencing the stressor.

The data revealed that the total of resident behavior problems and needs was moderately correlated with level of perceived stress. This suggests that resident behavior problems serve as a significant stressor for home operators whose residents have such problems, and that this stressor initiates the process of stress appraisal. Physical care needs did not emerge as a significant correlate with stress, indicating that it may not be as major a stressor as is the total of resident behavioral needs.

The finding that age is moderately negatively correlated
with stress lends support to the theoretical concept that characteristics of the individual impact the appraisal made of the situation. Age was found to explain the greatest amount of variance in perceived stress, indicating that individual attributes can make a significant impact in the appraisal which is made of the stressor.

Another individual characteristic which was found to impact the stress appraisal made was the extent to which the home operator perceived that caregiving had benefitted him or her with companionship. Several potential benefits were included in the study, but only one—companionship—was found to have a low negative correlation with level of perceived stress. This suggests that individuals who believe that operating an adult care home provides them with companionship are less likely to appraise the stressors of caregiving as stressful.

Future Research

The results from this study suggest a variety of areas for future research on this topic. Further exploration of the relationship between stress and the independent variables of finance and social support needs to be made to determine whether or not a correlation truly exists. As has been suggested, this further study should include a measure of financial status which assesses the home operators'
subjective impressions of the adequacy of their finances. Future research should also include a measure of social support which identifies the substitute caregiving support available to the operator.

The data in this study also indicate that a longitudinal study of stress in home operators would be valuable. Examination of the home operator over time would reveal whether stress does change across the caregiving career. Results would also clarify whether home operators do close their homes when their health declines or when they become extremely stressed.

Future research should also be designed to include portions of the stress theory model which were not included in this study, especially the coping mechanisms utilized by home operators when confronted with events which they perceive as stressful. Additional studies on this topic should also include other types of adult care homes to identify any differences in levels of stress or variables which correlate with stress. It would also be instructive to compare homes in differing states with varying forms of regulation and enforcement, to identify any impact that type of regulation may have upon level of perceived stress.
REFERENCES


George, L.K. (1987, July). Respite care and support groups: Benefits for caregivers and barriers to use. Paper presented at a conference of the Benjamin Rose Institute, Cleveland, OH.


McClave, M. (1982) *Personal Care Homes: Nowhere Else to Go!*. Atlanta, Georgia: Long-Term Care Ombudsman Program of Metro Atlanta


Montgomery, R.J.V. (1987, July). Issues in the use of volunteer programs and educational groups for family caregivers. Paper presented at a conference of The Benjamin Rose Institute, Cleveland, OH.


Adult Care Home Operator Interview

Thank you for agreeing to participate in this interview today. You received a letter and a study summary which described this study and which explained what you will be asked to do as a participant. Have you read the letter and the summary sheet?

IF YES: Do you have any questions about the study before we begin?

IF NO: I would like you to read the summary sheet before we begin. (Offer to read it to the home operator).

Before we begin, I want to remind you that your participation in this study is completely voluntary. If there are any questions that you do not want to answer, please let me know and we will skip those items. Also, you are free to ask that the interview be stopped at any time. In addition, I want to remind you that all of your responses will be kept completely confidential.

GENERAL INFORMATION

I would like to start the interview by asking you some general questions about your adult care home.

1. When did you start providing care in your home (month and year)？

2. How many residents are living here currently？

3. What is the largest number of residents that you can take at any one time？

4. Is your home certified, approved, or licensed by any agency, system or program? Yes ____ No ____
   (If yes) By whom？
   (circle all that apply)
   1 County Department of Human Services
      (approve family homes, certify Optional State Supplement family homes)
   2 Mental Health System
      (Licenses homes)
   3 Veterans Administration
      (Approves homes)
   4 Ohio Department of Human Services
      (Licenses Group Homes)

5. On the average, what is your monthly charge for care？
   (If there is a range, ask "What do most of your residents pay?")
CAREGIVER INFORMATION

Now, I would like to ask you some questions about yourself, since you are the primary caregiver here in your home.

Gender (observe)  
0 Male
1 Female

Race (observe)  
1 Black
2 White
3 Hispanic
4 Asian
5 Indian

1. What is your age? ________________

2. Are you  
1 Married
2 Single
3 Divorced
4 Widowed
5 Separated

3. How many children are living at home with you? __________

4. Do you have one or more family members who assist you in providing care?  
Yes____ No____  
(If Yes) How many family members assist you? __________
How many hours per week do you receive help from family members? __________

5. Have you had any formal training in providing care? Yes____ No____  
(If Yes) What kind of training have you received? ______________________________

6. Have you ever been employed in a health care setting such as a hospital, nursing home, or doctor's office? Yes____ No____  
(If yes) How many years of health care employment have you had? __________

7. What is your monthly income apart from money that you receive from caring for your residents?  
(Not counting the money that you get from your residents, what is your monthly income?)
8. Which of the following services do you provide to your residents? Do you

Provide three meals per day? Yes ___ No ___
Do resident laundry? Yes ___ No ___
Clean resident living areas? Yes ___ No ___
Provide transportation? Yes ___ No ___
Supervise residents' medications? Yes ___ No ___
Provide assistance, when needed, with bathing, dressing, and grooming? Yes ___ No ___
Provide 24-hour supervision? Yes ___ No ___

9. Do you feel that your current health is

5 Very Good
4 Good
3 Satisfactory
2 Not So Good
1 Bad

PERCEIVED BENEFITS

I am going to ask you about the ways in which running an adult care home has benefited you. On a scale of zero to five, with zero being not at all and five being a great deal, please rate the extent to which operating an adult care home has benefited you in each of the following ways:

1. To what extent do you feel that operating a home has benefitted you financially? 0 1 2 3 4 5

2. To what extent do you feel that operating a home has benefitted you by giving you the satisfaction of helping others? 0 1 2 3 4 5

3. To what extent do you feel that operating a home has benefitted you by enabling you to work at home? 0 1 2 3 4 5

4. To what extent do you feel that operating a home has benefitted you by the companionship that the residents provide to you? 0 1 2 3 4 5
RESIDENT CARE NEEDS

Now, I am going to ask you about the types of care needs which each of your residents has. I want you to tell me about the types of care that you provide for each of your residents, but I do not want you to give me any information about the resident that might enable me to identify him or her, such as a name or initials. What I will do is ask about your residents one by one, referring to them as the "first resident", "second resident", and so on.

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<th>How old is your X resident?</th>
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<td>In terms of supervision, does your X resident need</td>
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<td>1 Routine supervision</td>
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<td>3 Constant watchfulness</td>
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<td>For meals, does this resident</td>
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<td>3 Need a special tray</td>
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<td>taken to him/her</td>
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<td>2 Eat with the other residents</td>
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<td>2 Eat alone</td>
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<td>For hygiene care, does this resident</td>
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<td>2 Need urging/monitoring</td>
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<td>3 Need direct assistance</td>
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<td>When going out to an appointment, does this resident</td>
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<td>2 Go in a group</td>
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<td>3 Need to have you take him/her</td>
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<td>Regarding medications, does this resident</td>
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<td>1 Have no medications</td>
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<td>2 Take his/her medications willingly and has only a few to take</td>
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<td>3 Take his/her medications willingly and have to take them frequently</td>
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<td>3 Take his/her medications reluctantly</td>
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<td>Does this resident currently have a secondary physical problem such as a cold or flu?</td>
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7. In terms of this resident's behavior, is he/she
   2 Demanding of Time or Anxious
   3 Angry or weeping
   2 Withdrawn
   3 Assaultive
   3 Acting Out in Other Ways
   2 Wandering

8. Did this resident just move in?
   2 If Yes

9. Is this resident going to move out soon?
   2 If Yes

TOTALS

Total Score_______ Total on Behavioral_______ Total on Other_______

CAREGIVER STRAIN

Now, I want to learn more about your experiences as an adult care home operator. I am going to read a list of experiences which many people encounter when caring for people in their homes. Please tell me how often you experience each of them: rarely or never, a little of the time, sometimes, often, or most of the time.

1. How often do find that your sleep is disturbed (e.g. because residents are out of bed or wander at night)?
   1 Rarely or Never
   2 A Little of the Time
   3 Sometimes
   4 Often
   5 Most of the Time

2. How often do you find that it is inconvenient (e.g. because caregiving takes so much time)?
   1 Rarely or Never
   2 A Little of the Time
   3 Sometimes
   4 Often
   5 Most of the Time

3. How often do you find that it is a physical strain (e.g. because of helping out of a chair or the bathtub)?
   1 Rarely or Never
   2 A Little of the Time
   3 Sometimes
   4 Often
   5 Most of the Time
4. How often do you find that it is confining (e.g. because caregiving restricts free time, or you cannot go visiting)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

5. How often do you find that you have to make family adjustments (e.g. because caregiving has disrupted routine; there is no privacy)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

6. How often do you have to make changes in your personal plans (e.g. could not go on vacation)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

7. How often do you find yourself making emotional adjustments (e.g. residents leave or pass away)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

8. How often do you find that you have other demands on your time (e.g. such as from your family members)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

9. How often do you find that some resident behavior is upsetting (e.g. because of incontinence, being confused or forgetful, or acting out)?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

10. How often do you find that it is upsetting to see residents have physical and emotional declines?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time

11. How often do you find that it is a financial strain?

1. Rarely or Never
2. A Little of the Time
3. Sometimes
4. Often
5. Most of the Time
12. How often do you feel completely overwhelmed (e.g., because of worry about the residents, concerns about how you will manage)?

1 Rarely or Never
2 A Little of the Time
3 Sometimes
4 Often
5 Most of the Time

13. How often do you find it frustrating to work with different agencies?

1 Rarely or Never
2 A Little of the Time
3 Sometimes
4 Often
5 Most of the Time

14. How often do you find it is frustrating to deal with residents' family members?

1 Rarely or Never
2 A Little of the Time
3 Sometimes
4 Often
5 Most of the Time

OPEN-ENDED RESPONSE QUESTIONS

I want to conclude our interview today by asking you some open-ended questions about your experiences as an adult care home operator.

1. What do you find to be the most stressful aspects of operating an adult care home?
2. What do you feel are the most beneficial, enjoyable or rewarding aspects of operating an adult care home?

3. What services, programs, or laws would make your job as an adult care home operator easier and/or less stressful?
Those were all the questions that I had to ask you today. Is there anything else about operating an adult care home that you would like to tell me?

Home Location: County: 1 Cuyahoga Setting: 1 Urban
2 Geauga 2 Suburban
3 Lake 3 Rural
4 Lorain
5 Medina
Dear Adult Care Home Operator:

During the coming months, I will be conducting a research study on the experiences of adult care home operators in Cuyahoga, Geauga, Lake, Lorain and Medina counties. The purpose of the study is to obtain information about what it is like for you to operate an adult care home, and to understand the stresses that may be a part of your work. The information gathered from this research will be used to inform policy makers and social workers about your caregiving, and to encourage the development of programs and services which will assist you in your work.

I would like to invite you to participate in this study and to share your unique and valuable experiences as an adult care home operator. If you agree to participate, an interviewer will come to your home and will conduct an interview that is approximately 30 to 45 minutes in length. She will call ahead and set up an appointment to come at a time that is convenient for you both. She will ask you questions about your home, your work, the types of care you provide, and how you feel about being a caregiver. Everything you say will be kept strictly confidential, and your name will not be attached to your questionnaire. You will also be free to refuse to answer any question that you do not want to answer, and you may stop the interview at any time.

I have enclosed a sheet which summarizes the study and tells more about the interview. If you have any questions about the study, either before or after your interview, please feel free to call me between 9 AM and 5 PM, Monday through Friday, at 621-8322. An interviewer will be contacting you within the next few weeks to set up an interview with you.

Thank you in advance for your time and involvement in this research. Your candid responses will enable service providers and policy makers to better understand what kinds of programs and assistance you need to do your job well.

Sincerely,

Sally Reisacher
Summary of Study of Adult Care Home Operators

Purpose of the Study: The study which you have been asked to participate in is being done so that social workers and people who make public policy can better understand what it is like to be an adult care home operator, and so they can better understand the stresses that may be part of your caregiving job.

Who is doing the study: My name is Sally Reisacher, and I am a social worker. I am doing this study independently from any social service agency or state agency. The results of this research will be shared with agencies in Ohio and throughout the country which work with adult care home operators and residents. Results will also be shared with policy makers around the state and the nation, so that they can understand what your work is like, in what ways it is stressful to you, and what services or programs you would find helpful to assist you in your work. The results will also be used in part to fulfill requirements for a social work degree at Case Western Reserve University.

Why your responses are so important: Being an adult care home operator is a difficult, 24-hour a day job. This study will gain information from you about what your work is like, and will hopefully identify what social service agencies and the policy makers can do to help you as you provide care to your residents. These groups cannot know what it is like for you to care for people in your home unless you share your unique insights and experiences.

What you will be asked to do: You are being asked to take part in an interview which will last about 30 to 45 minutes. An interviewer will call you and ask to set up a time to come to your home and speak to you. The interviewer will ask you a series of questions about yourself, your home, the types of care that you provide to your residents, and how you feel about some of your caregiving experiences.

There are some very important things that you need to know about this interview.

**Your participation is completely voluntary. You can choose if you want to talk to the interviewer or not.

**During the interview, you only have to answer the questions that you want to answer. If there is a question that you do not want to answer, you can skip it.
**You can withdraw from the study at any time. All you have to do is tell the interviewer that you want to stop.**

**Most important, everything that you say will be kept confidential.** Your name and address will not be listed on the interviewer's form anywhere, and your name and any identifying information will not ever be given out or used when the results of the study are written up. The same is true for your residents. You will be asked some questions about the kinds of care that you provide, but interviewers will not want any identifying information about your residents, such as their names.

**If you have any questions:** Please feel free to ask any questions you may have at any time: before, during, or after the interview. You can call me, Sally Reisacher, at 621-8322 Monday through Friday, 9:00 AM to 5:00 PM. If I am not in, leave a message and I will get right back to you.