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Residential Care Operators:
Sources and Mediators of Stress
by

Lou Ellen Ann Barnes

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**RESIDENTIAL CARE OPERATORS:
SOURCES AND MEDIATORS OF STRESS**

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DEDICATION

This dissertation is dedicated to David Barry Willis, my husband, whose tolerance, encouragement, and love made this process possible.

ACKNOWLEDGEMENTS

A project of this length can only be accomplished with the support and encouragement of so many. I offer my sincere gratitude to my mentor at Stanford University, Jacqueline Dunbar, RN, PhD, for her vision and direction.

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ABSTRACT

RESIDENTIAL CARE OPERATORS: SOURCES AND MEDIATORS OF STRESS

Lou Ellen Ann Barnes

The purpose of this study is to describe the sources and mediators of stress of residential care operators (RCO) who live with and care for adult mentally ill individuals. The possible association between stress and social support, on the one hand, and the residential care operator's level of physical health and psychological well-being, on the other, is also examined.

Residential care operators (N=40) from two counties in Northern California were included in this convenience sample. A focused interview and questionnaires were used to collect data. Structured interviews were conducted to elicit in-depth data on stressors, coping strategies, and social support. In addition to demographic information, three questionnaires were used: The Norbeck Social Support Questionnaire, the Health Questionnaire, and the Bradburn's Morale Scale. The data were analyzed using qualitative and quantitative analyses.

A variety of findings emerged from this study, not the least of which that client-related problems were reported most often as the highest stressor. Distressing client behaviors such as threats of violence toward themselves or others were among the other greatest stressors. Personal stressors included the lack of relief from work responsibilities; environmental stressors included financial, licensing, and problems in communicating with professionals.

Similar to mental health professionals, the subjects utilized problem-focused coping strategies in dealing with their highest ranked stressors. The primary sources of support for dealing with the highest ranked stressors were reliance on themselves followed by counseling from mental health professionals. These subjects expressed the need for professionals to provide more information and help with client emergencies.

Results of correlational analyses indicated that subjects who had higher levels of social support reported less distress with client-related behaviors. Operators who had been in business reported higher social support. However, these operators reported more distress with environmental stressors.

From this study it can be concluded that, in general, living with and caring for mentally ill individuals is extremely stressful. Furthermore, professional support was oftentimes lacking in these situations. These results suggest the importance of inclusion of RCOs in community support programs.

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CHAPTER I

INTRODUCTION

Residential care operators provide supervised, 24-hour home environments seven days a week to severely mentally ill adults who live in the community. They are "first-line" caregivers who assume responsibility for meeting the essential needs of food, shelter, care, and support. They care for clients whose psychiatric symptomatology from the illness has interfered with their ability to live in a fully independent setting. These clients frequently lack connections with their naturally occurring networks that might provide them with their fundamental needs. Further, these clients reimburse residential care operators for service out of disability benefits they receive, which are at a fixed, low-income rate. Thus, residential care operators are in a difficult situation of caring for some of the most challenging psychiatric clients who have complex needs in the context of limited resources. These operators are vital members of the mental health care team whom psychiatric nurses and others rely upon for care of patients.

Recent statistics about psychiatric illness support the continuing need for this caregiving role. Currently, Segal and Kotler (1989a) estimate that 25 percent of all chronically mentally ill individuals live in sheltered care facilities, a greater proportion than those who live in state mental hospitals. Of all sheltered care facilities, approximately 72 percent are board-and-care, or residential care facilities (Segal & Aviram, 1978). A survey by the National Association of Residential Care Facilities (1987) reported over 41,000 licensed care homes in the United States. Further, the General Accounting Office

(1989) reports that the State of California has approximately 19 percent of the total number of licensed residential care homes nationally.

During the last three decades, the number of chronically mentally ill individuals living in the community has dramatically increased (Bromet & Schulberg, 1989). This trend is expected to continue while the exact number of chronically ill individuals is difficult to determine, it is estimated of the two million chronically mentally ill people in the United (Goldman, Gallozzi, & Taube 1981), 93 percent reside outside of state mental hospitals (Goldman, Taube &, Regier, 1983). Further, the largest single subgroup of chronically mentally ill persons living in the community have schizophrenia.

Statistics show that the prevalence of severe mental illness has not declined. Currently, the literature shows an increased number of younger adult persons with mental illnesses who have very high service needs. An epidemiological study reported higher rates of schizophrenia disorders in groups under the age of 45 years as compared to other age groups (Regier, et al., 1988). Because this younger group of clients is aging, and because an increasing percentage have co-occurring substance abuse problems, they will have multiple service needs that make them more dependent on resources such as residential care facilities in the future. Further, in certain mental illnesses, such as schizophrenia, adult children may survive their parents' support networks (Williams, Williams, Sommer, & Sommer, 1986), becoming dependent upon the public sector's resources.

Another factor influencing the need for residential care homes is the large number of mentally ill persons who are at risk for homelessness. Although accurate data on what proportion of the homeless are mentally ill do not exist, estimates range from 25 percent to 50 percent of homeless persons who are mentally ill (Robertson & Cousineau, 1986). Further, as the urban real estate base diminishes through redevelopment and as federal entitlement programs decline, the number of homeless persons is increasing (Carling, Daniels, & Ridgway, 1985). The lack of housing resources for the disabled and the urban poor and the increasing number of homeless mentally ill indicate the need for services to meet the needs of this population for residential care placements.

In contrast to rising demand, however, residential care homes may be a diminishing resource. Some urban areas are losing numbers of residential care homes. For example, the San Francisco Task Force on Housing (Blaustein & Viek, 1987; Viek, 1985) reported a decrease of 41 percent in the residential care homes in San Francisco during the last ten years. The reasons for this loss are unclear. Explanations include the following: 1) operators who have been in the business for years are retiring now and not being replaced by new operators; 2) high costs of real estate and mortgages, in combination with cutbacks in federal and state programs for mentally disabled persons, prevent potential operators from purchasing homes; 3) the state-approved deductions for payments to residential care facilities fall behind the inflationary costs of mortgage payments, food, insurance, and taxes (Fleishman,

1985); and 4) some operators have changed their licenses to care for developmentally disabled persons since they receive higher state supplements as compared to caring for mentally ill persons. Whatever the root causes, these vital housing resources appear to be decreasing in urban centers.

In summary, as the population of chronically mentally ill persons who are in need of shelter and care increases, the number of residential care homes may be declining, creating a serious lack of this vital resource. Residential care homes are an integral component of a comprehensive mental health system and the need for these homes is expected to increase (Segal & Kotler, 1989b). Thus, it is crucial that the concerns and needs of the operators of these homes be studied so that supportive interventions can be designed to enable these caregivers in continuing to serve the needs of the mentally ill.

Statement of the Problem

The lack of research about residential care operators creates a major knowledge gap regarding these caregivers who provide essential care and housing for chronically mentally ill persons. The body of the literature concerning caregiving to the severely mentally ill is almost exclusively focused on relatives. This research on family caregivers provides information on various aspects of the caregiving experience, such as the stresses they experience, their support resources, and the psychological impacts of caregiving (Baillie, Norbeck, & Barnes, 1988). In a parallel line of inquiry, professional caregiver concerns and needs

have received scant attention. Understanding the stresses and support needs of residential care operators may help preserve this valuable service resource for chronically mentally ill individuals.

Despite the developing body of research on family and professional caregiving, little is known about the stresses, resources, and psychological well-being of residential care operators. There are a few anecdotal accounts of residential care operators (Bailey & Brodaty, 1982; Beatty & Seeley, 1980; Drake & Osher, 1987; Dubin & Ciavarelli, 1978). Articles concerning clinical consultation to residential care operators exist (Flagg, 1982; Fleishman, 1989; Lamb & Peterson, 1983; Peterson, 1979; Peterson, 1985). A statewide study that primarily focused on mentally ill residents who live in these facilities examined the influence of manager style on residents' community integration (Segal & Moyles, 1979). Only one recently published survey addressed the stresses of these operators (Blaustein & Viek, 1987). Thus published literature and research about residential care operators are extremely limited.

Residential care operators are a group of caregivers who are in some respects unique. They live with and assume responsibility for two or more residents 24 hours a day. While mental health professionals care for many patients for eight hours, family caregivers generally live with one relative full-time. However, neither professionals nor family members do both.

Family caregivers who live with their mentally ill relative maintain a parallel role to residential care operators in some respects.

Both families and residential care operators live with and care for mentally ill individuals on a 24-hour, seven day a week basis.

Literature on family caregivers suggests that they contend with many stressors with regard to living with mentally ill persons. Problems that families experience with psychiatric illnesses include coping with disturbing behaviors, disruption in family role responsibilities, and stigma. It is unknown, however, how families and residential care operators differentially experience caregiver stressors, cope with these stressors, or use supports. It is also unknown how stressors affect residential care operators.

Purpose of the Study

The purpose of this study is to describe the stressors associated with the role and resources, including coping and social support, of residential care operators in response to living with and caring for adult mentally ill persons in the community. The two main objectives for this study were: (a) to identify specific coping strategies and social support needs associated with the stressors of providing care, and (b) to explore the relationship between the sources of stress and social support to the adaptational outcomes of physical health and psychological well-being.

Significance of the Study

The shift of care of long-term mentally ill persons from state hospitals to communities has created new demands for nonprofessional

caregivers, such as residential care operators. These important, paid nonprofessional caregivers serve an important group of schizophrenic and other chronically mentally ill individuals. The complex mental health system, with its limited governmental funding, changing regulations, and the poorly designed programs, may be significant potential stressors for residential care operators, over and above the inherent challenges posed by the psychiatrically ill clients they serve. Therefore, the difficulties of their work and role make us concerned with the support that is available to these operators.

One can only postulate why there has been so little research on residential care operators, leaving a void of knowledge of the major concerns and needs of these caregivers and the factors that contribute to their stress level. From a sociological perspective, stigma associated with those who care for the chronically mentally ill is evidenced in the literature on families with mentally ill relatives. Community opposition and negative community reaction to the development of new facilities is well documented (Boyer, 1987; Zanditon, 1988). Also, media coverage of isolated problems associated with unlicensed homes has contributed to proliferating negative images and stereotypes associated with residential care (Segal & Aviram, 1978). In addition, "reports on system abuses by the General Accounting Office, Social Security Administration, and the Congress have depicted the whole board-and-care system as an aggregation of inferior residential settings run by profit-hungry owners and managers" (Segal & Kotler, 1989a, p. 257). Further, Gardner and Scheffler (1988) assert that the U.S. mental health

system's detachment and failure to fund, collaborate, and support these facilities because they are considered private, for-profit enterprises contribute to separation of these facilities from the public system. These are but a few possible explanations of why there is a paucity of research specific to residential care operators.

It is crucial that research that addresses the concerns and needs of residential care operators be conducted. Residential care operators are in the vanguard of community care, providing vital linkages between clients, mental health professionals, and services. The study on stressors and mediating resources of residential care operators can do much to explicate the unique needs of these operators and to develop interventions that will enable them to face the difficult tasks of their work with a greater sense of support and acknowledgement for their important contributions to the care of mentally ill individuals.

Background to the Study

Use of the residential care facility as a home for mentally ill clients is an outgrowth of contemporary public policies and legislation. In order to study the phenomenon of caregiving for the severely mentally ill, two major background areas need to be explored. First, it is essential to review the deinstitutionalization process in the United States and its influence on the use of the community residential care homes as a mental health facility. Second, it will be helpful to review the special characteristics of social environments that appear to affect

schizophrenic persons, using the recent contributions to the literature which fall within a stress-vulnerability model.

Deinstitutionalization and the Shift to Residential Care

In the decade after World War II, a reform movement called deinstitutionalization began the process of shifting the long-term mentally ill from state hospitals to communities (Chafetz, Goldman, & Taube, 1983; Mechanic, 1987). In 1955, there were 559,000 patients in public mental hospitals. By the mid-1980s resident census in public mental hospitals decreased to 115,000 (Mechanic, 1989). Factors such as the introduction of antipsychotic medications, the community mental health movement, legal interest in the civil rights of patients, fiscal needs to shift the cost of care, and research demonstrating the debilitating effects of long-term hospitalization on adjustment to the community gave impetus toward the shift in the care for mental patients from hospitals to community-based care (Test & Stein, 1978).

The Community Mental Health Centers (CMHC) Act of 1963 began the first national policy for community care for the mentally ill (Chafetz, et al., 1983). The purpose of this legislation was not only to relocate the mentally ill to more humane environments but also to promote self-determination and social reintegration of the mentally ill into communities. The long-term goal was to gradually eliminate large custodial care mental institutions.

The 1963 CMHC Act failed to anticipate the range of services needed to maintain the severely mentally ill in communities. Although

this act of legislation established the community mental health model and stipulated essential services, these services were oriented toward treatment needs of clients rather than support needs such as housing. In fact, effective community care for the severely mentally ill requires many of the same functions as the mental hospital, including assuring appropriate shelter and providing care (Mechanic, 1989). Unfortunately, however, the resources and funds of the public institutions did not follow the discharged patients into the community (Bachrach, 1978; Mechanic, 1987). Thus, vital resources such as housing, financial aid, continuity of care, transportation, vocational, and recreational services were severely lacking. Nevertheless, federal laws were enacted and financial programs created that provided states with the incentive to reduce the number of their hospital beds.

Federal funding programs that facilitated the shift toward community care of the chronic mentally ill who were highly disabled and unable to support themselves were Medicare, Medicaid, and Supplemental Security Income (Rubin, 1981). The intent of Congress in establishing SSI was to encourage the transfer of mental patients in state hospitals to community settings (Levine, 1981). These Social Security programs contributed largely to deinstitutionalization by providing extension of the benefits to the adult mentally ill in the community. With the introduction of these funds, the residential care industry developed.

Because a proportion of the chronically mentally ill were unable to establish residences and live independently, structured and supervised environments were thought to be their best living

arrangements (Lamb, 1979; Linn, et al., 1985). Thus, many discharged patients went to nursing homes and residential care facilities.

The Range of Residential Settings

According to Boyer (1987), the residential home industry developed as a business opportunity during the 1960s. With community resistance and lack of adequate funding, private, fee for service residential care facilities, became the default recipients of thousands of chronically mentally ill. A spectrum of residential care facilities were created to offer a wide range of care and supervision to meet the different functional needs of mentally ill persons. In an attempt to clarify the definitional issues, the American Psychiatric Task Force on Community Residential Services (Arce, Vergave, Adams, & Lazarus, 1982) has suggested a typology of facilities. The Task Force proposed a continuum of community residences from most to least restrictive environment: nursing facility, group home, personal care home, foster home, natural family placement, satellite or transitional housing, and independent living.

In the State of California, the Health and Welfare Agency of the Department of Social Services has its own nomenclature with a broad definition of adult residential care facility (e.g., residential care home includes group homes and personal care homes). For licensing purposes, "Adult Residential Facility" refers to any facility of any capacity which provides 24-hour a day nonmedical care and supervision to adults except elderly persons (State of California, 1984, 80001a4).

Care and supervision includes a wide range of services. The California Administrative Code, Title 22 (1980), outlines the minimum standards of care required of residential care operators for mentally disabled persons. The definition is as follows:

Care means assistance as needed with activities of daily living and the assumption of varying degrees of responsibilities for the safety and well-being of residents. Care and supervision shall include, but not be limited to, any one or more of the following activities provided by a person or facility to meet the needs of the residents: (1) Assistance in dressing, grooming, bathing, and other personal hygiene; (2) Assistance in taking medication; (3) Central storing and distribution of medications; (4) Arrangements of an assistance with medical transportation; (5) Maintenance of facility curfews for residents; (6) Supervision of residents' schedules and activities; (7) Maintenance of supervision of resident monies or property; and (8) Monitoring food intake or special diets.

Schizophrenia: The Stress-Vulnerability Model and the Social Environment

Schizophrenia

Goldman (1982) estimated that approximately 1.1 million adults with severe psychiatric disabilities were in households in the community. Of these persons, 87 percent lived with relatives or unrelated household members, such as residential care operators. Schizophrenia comprises the largest single subgroup of chronically mentally ill clients. Goldman, Gattozzi, and Taube (1981) estimate that approximately one-half of all chronically mentally ill individuals have a diagnosis of schizophrenia.

Schizophrenia is a devastating illness that on the average afflicts one person out of every 100 (Andreasen, 1986). With its onset most often in adolescence or early adulthood, schizophrenia is an illness with acute episodes and remissions, often with the possibility

of increasing residual impairment between episodes (APA, 1987; Herz, 1986). There are debates concerning (a) whether the course of the illness is chronic or episodic and (b) the specific subtypes of illnesses in schizophrenia.

Long term follow-up studies of schizophrenia have identified a variety of outcomes, ranging from symptomatic remission to a progressive deteriorating course, with deficit symptoms of apathy, underactivity, and amotivation (Harding et al., 1987). Such variability may be determined, at least in part, by a multitude of social environmental factors, including psychosocial rehabilitation and living environments that may significantly contribute to the development of chronicity (Harding et al., 1986a; 1986b). This makes the study of social environments of schizophrenia and their caregivers in these environments a significant area of study. Therefore, it is essential, in determining common supports for the severely mentally ill, to understand stress, the usual developmental course of schizophrenia, and its relationship to stress.

Stress-Vulnerability Model

Acute episodes of schizophrenia appear to be at least partially a function of environmental stressors. Vulnerability-stress models are a framework for the study of multiple factors involved in schizophrenia and currently provide a useful mechanism for understanding person and environmental interactions in the development of this illness. Vulnerability-stress models elaborated by various sources encompass many similar components. These include biologically-based

neurophysiological, neuroanatomical, genetic conditions on one hand, as well as environmentally-based ecological, developmental, and learning factors on the other (Nuechterlein, 1987; Zubin & Spring, 1977; Zubin, Steinhauer, Day, & Kammen, 1985). Thus, these models consider an individual's personal biological vulnerability within the context of environmental stressors and supports.

The combination of environmental stressors with the person's pre-existing vulnerability can lead to development or exacerbation of psychotic symptoms. Research testing this model supports the hypothesis that schizophrenic persons are highly sensitive to stress in their social environments (Drake & Sederer, 1986). Such stress is likely to occur when life events exceed their coping abilities (Thurm & Haefner, 1987); when their families and social networks are nonsupportive (Beels, 1981); when they are not protected by antipsychotic medications (Herz, 1986; Kane, 1987); and their community support systems do not provide the necessary mental health treatment, rehabilitation, and housing (Lieberman, 1988).

Household Stress

Environmental stressors are hypothesized as being capable of lowering the person's vulnerability threshold to the onset of schizophrenic episodes or course of the illness (Leff, 1989; Zubin & Spring, 1977). The main area of research on interpersonal environments in the community has examined the relationship between familial stress and schizophrenic relapse. These studies began with a British researcher's interest in examining the environments of discharged

schizophrenics who returned to the community to live with key persons such as mothers, wives, sisters, and landladies (Brown, 1958). This researcher found that patients who changed their living situations from their parental or spousal homes to a lodging home (e.g., similar to residential care facility) were more successful in staying out of the hospital for one year, compared with those who did not change residences. Thus, Brown (1958) concluded that it is not always beneficial for schizophrenic persons to return to live in family environments that were intense and emotional. This seminal work gave impetus to the many studies that further examined the affective family environments of schizophrenics. Little attention since this study, however, has been given to the potential influence that persons in alternative, nonfamily households may have on schizophrenics. This is an important area for future research.

In a subsequent study, Brown, Birley and Wing (1972) studied 101 patients and their families at onset of treatment and nine months after discharge from the hospital. They made ratings of the extent to which a key relative made critical or hostile comments about the patient or comments that indicated emotional overinvolvement with regard to the patient during the intake interview for psychiatric hospitalization. High negative expressed emotion (EE) by relatives of schizophrenics means that these relatives made more negative comments about their schizophrenic member than relatives who were evaluated as being low in negative expressed emotion.

These researchers found a significant relationship between high EE by relatives and relapse within or at the nine month follow-up (Brown et al., 1972). They also found that patients living with high EE relatives who spent less time with their relatives (i.e., spent less than 35 hours a week) had lower relapse rates when compared to high EE patients who spent more time with their relatives. These researchers concluded that the post-discharge family environment independently predicted relapse.

Vaughn and Leff (1976) and Vaughn et al. (1982) replicated the study by Brown, et al. (1972). The findings of Brown et al. (1972) were corroborated by these studies. A high degree of negative EE by relatives at the time of admission was a predictor of symptomatic relapse during the nine month period following discharge. In addition, Vaughn and Leff (1976) found that a reduction of face-to-face involvement with family members in combination with continuing to take psychotropic medications reduces the rate of relapse.

Several intervention studies have demonstrated that working with families can be effective in reducing expressed emotion and thus protective in preventing relapse. Family intervention in the rehabilitation of schizophrenic persons when combined with neuroleptic medication, have demonstrated significant decrease in relapse rates despite the various family intervention methods (Berkowitz, et al., 1981; Hogarty, et al., 1986; Leff, Kuipers, Berkowitz, Eberlein-Fries, & Sturgeon, 1982). The strength of these intervention studies is the experimental design which includes random assignment to treatment and control groups.

These intervention EE studies demonstrate how the social environment can be either protective or stressful for schizophrenic persons. Supportive, nonintrusive family behaviors are protective against the onset of psychotic relapse. Overprotective, critical family behaviors may contribute to stress. Thus, decreasing the emotional intensity of the family is associated with decreased risk of relapse. More important in terms of professional intervention, supportive psychosocial interventions that increase the family's problem-solving and coping with difficult behaviors are potentially protective. More generally these studies suggest that interventions with the social network as well as the patient can be effective in reducing relapse rates.

Overall, the research of families' EE indicates the significant role environmental factors play in the risk of relapse in the nine months following hospital discharge. This research collectively supports the proposition that affective intensity influences symptomatic outcomes in schizophrenics. Thus, there is evidence for the responsiveness of schizophrenia to social factors.

Debates continue about whether or not the construct of EE validity represents an enduring trait of relatives that is always present or a reaction that is situationally dependent on the crisis of hospitalization (Miklowitz, Goldstein, & Falloon, 1983; Platman, 1983). Although this construct validity issue needs to be addressed in longitudinal research designs, EE is a relevant clinical construct for evaluating the affective climate of family members who live with a

schizophrenic relative. Thus, expressed emotion has developed from a predictive index to a clinical construct which can be manipulated as an independent variable in intervention studies (Koeningsberg & Handley, 1986).

Given increasing indications that social environments can be stressful or protective, and despite Brown's (1958) earlier findings that patients in lodging homes stayed out of the hospital longer than those who lived in parental or spousal homes, it is surprising that only the family has been studied. Community care of schizophrenics involves an extended psychosocial network of key persons that not only includes relatives, but also persons such as friends, neighbors, and residential care operators (Strachan, 1986). To my knowledge, only one published report to date has explored intervention with a high-EE residential care operator (Drake & Osher, 1987). They found that support, education, and collaborative problem-solving were helpful for a nonfamily caregiver to implement appropriate behavioral limits with patients and to monitor his or her own tolerance of distressing behaviors. Although this single case study needs to be replicated with larger sample sizes and more rigorous research designs, the concept of expressed emotion (EE) may apply to persons other than family members. Although EE is not the primary focus in the present study, it demonstrates the salience of social environments, and thus, the importance of residential care operators who provide housing, care, and supervision of schizophrenics and other severely mentally ill individuals in the community.

CHAPTER II

LITERATURE REVIEW, CONCEPTUAL FRAMEWORK, AND RESEARCH QUESTIONS

Residential Care

Residential Care Facilities: A Review of the Studies

The research on residential care facilities in the last several decades has focused primarily on the community adaptation of patients who live in these homes. This research identifies patient characteristics and facility characteristics which influence successful patient outcomes. Although the concerns and needs of residential care operators was not the focus of this prior research, this extensive research provides background information about residential care facility environments and the patients who live in them.

Early Descriptive Studies

Many initial studies of residential care facility programs enthusiastically praised the benefits of community care. Exemplary model programs in halfway houses proliferated in the early 1960s to mid-1970s (Carpenter, 1978). These halfway houses were often alternatives to hospitalization for young, first-psychotic break individuals (Mosher & Menn, 1977; 1978). The major contributions of these programs were their innovative approaches such as using nonprofessionals (e.g., graduate students at Soteria House) in treating patients in residential settings (Wilson, 1982). Halfway houses by definition are "transitional" residences that discharged patient use for a time-limited period. Residential care homes, in contrast, provide a more long-term living situation for clients.

Early exploratory studies (cf. Carpenter, 1978) anecdotally reported a variety of social and physical characteristics of residential living situations. The sample sizes were small or not specified, and no standardized instruments or control groups were used. Thus, the generalizability of the results is limited. However, these studies began the identification of important residential care facility characteristics as described below.

Social environmental characteristics of residential care facilities thought to be successful, for example, included staff who regarded residents as individuals, were less authoritarian (Christenfeld & Haveliwala, 1978; Reynolds & Farberow, 1977; Rosson, 1977); had available staff for support, were willing to explore alternatives (Winston & Lieberman, 1978; Reynolds & Farberow, 1977); offered protection but not closely monitoring (Carpenter, 1978); and provided opportunities to develop relationships with other residents (Carpenter, 1978; Christenfeld, Haveliwala, 1978). Physical characteristics preferred by residents were small home size, privacy, and space to socialize (Carpenter, 1978; Christenfeld & Haveliwala, 1978).

Evaluation Studies

Social integration. In a statewide study in California, Segal and Aviram (1978) evaluated the effect of sheltered-care facilities on patient social integration. This study is based on a probability sample of 214 sheltered care facilities in California. In this extensive study 499 formerly hospitalized adult mentally ill persons residing in sheltered-care facilities interviewed and followed and 234 operators of these facilities were interviewed. Sheltered-care facilities were

defined broadly in this study as any residence, excluding licensed hospitals and nursing homes, providing at least a minimally supervised living arrangement that widely ranged from halfway houses, family-care homes, or board-and-care homes. This data set was used to answer a variety of questions about the quality of social environments of mentally ill persons.

Segal and Moyles (1979), for example, examined operator management style and degree of dependency experienced by residents. The Community-Oriented Programs Environment Scale (COPES) (Moos, 1974) was used to construct a measure of management styles, either client-centered or management-centered. The size of management-centered facilities not surprisingly were, on average, larger than client-centered facilities. Also, residents in client-centered management facilities showed a greater level of interaction with staff. Facilities with highly regulated procedures that focused on management needs and management efficiency fostered more institutional dependency.

In another analysis, Segal, Everett-Dille, and Moyles (1979) examined whether congruent perceptions of their social environments by residents and operators would predict a resident's social integration. The outcome associated with the resident's well-being, was the level of involvement inside and outside of the facility (e.g. social integration) (Segal & Aviram, 1978). The agreement of residents' and operators' perceptions of the environment had a weak relationship to residents' social integration. However, the residents' assessment of their social environment as measured by COPES (Moos, 1974) was better than operators in predicting the extent to which the resident was involved in

activities inside and outside the facility. Thus, residents who perceived positive relationships, opportunities for growth, and low staff control in the residence were better integrated into their community situations.

In a recent survey of 851 mentally ill residents of board-and-care homes in seven states, Nagy, Fisher, and Tessler (1988) assessed a variety of facility characteristics such as size, rate of resident turnover, cost of care, operation for profit, staffing ratios, and location of the home with regard to resident participation in activities within and outside of the residence and productive activities of the resident. It is important to note that, corroborating earlier studies, the size of the facility accounted for twenty-five percent of the variance in participation in community activities. For example, residents living in owner-operator facilities engaged in more productive activities, but only if the facility was small. The researchers' interpretation was that residents who live in large facilities become less active because the environment is too stimulating or because residents are not given individual encouragement. Also, nonprofit facilities encouraged resident activity more than for-profit homes. These authors recommend that public policies be developed to support smaller, nonprofit homes for persons with severe psychiatric problems so that these persons can be encouraged to achieve their potential level of social integration.

A group of studies compared patient, facility, and community factors on social integration. Kruzich (1986) and Kruzich and associates (1985; 1986) studied 87 mentally ill individuals residing in

three types of residential care settings: skilled nursing facilities, intermediate care facilities, and congregate care facilities. Patient characteristics of overall psychosocial functioning, age, involvement with other persons outside the facility, and age accounted for only eight percent of the variance in social integration. Facility characteristics, such as facility operator's attitude toward social services, fewer number of residents, and an environment that emphasized individual's needs, accounted for 40 percent of the variance. For example, smaller facilities were associated with higher levels of social integration. This correlational study indicated the importance of fitting the patient's needs with the type of facility.

The balance of the structure of routines ($r = .34$, $p = .001$) and amount of skills programming for residents ($r = .36$, $p = .001$) was a statistically significant community factor that correlated with successful facility integration (Kruzich, et al., 1985). That is, too much or too little structure created environments that were too understimulating or too overstimulating, for clients. Thus environments that support residents' optimum level of functioning by encouraging their initiative and support their capabilities while maintaining realistic expectations for involvement positively affected social integration. Again, tailoring the structure to meet individual resident needs and capabilities is demonstrated in these studies.

The interaction of individual resident characteristics and specific facility and neighborhood type were studied with regard to social integration. Segal, Baumohl, and Silverman, (1989) reanalyzed personal characteristics of residents such as age, race, monetary

resources, psychiatric symptomatology, and substance abuse with eight different facility and neighborhood characteristics in which the residents resided. Residents' sharing of personal characteristics, such as ethnicity with the dominant social group of the home environment and neighborhood type significantly predicted social integration especially in homes in conservative, upper-middle class areas. Some interesting findings were found with regard to psychiatric symptomatology. Paranoid symptomatology was not associated with higher social integration in any of the eight environments. However, schizoid symptomatology was positively associated with social integration in facilities with more structured programs perhaps because these environments were less demanding on these patients.

Social adaptation. A pervasive issue in planning for the discharge and community placement of the mentally ill patient is balancing the patient's need for independence versus the patient's need for stability and consistency (O'Sullivan & Brody, 1986). Several researchers (Searight & Handal, 1983; Searight, Oliver, & Grisso, 1986) systematically studied patient needs for autonomy versus structure in community environments. As predicted, the highly structured and supervised board-and-care residents had significantly lower social competence scores as compared to low-structured cooperative apartment residents. These results, however, should be interpreted with caution. The correlation of patients' social competence with type of environment is not a unidirectional, causal relationship. That is, the type of environment may affect patients' social competence, or patients may be

placed in environments that are perceived by others as the best fit for them.

The fit between the person's needs and capabilities and resources of their environments were evaluated in a study of residents and mental health workers in community care homes (Coulton, Holland, & Fitch, 1984; Coulton, Fitch, & Holland, 1985). The patient's perception of congruence between his or her needs and the environmental resources accounted for forty-three percent of the variance in the patient's adjustment to community living as measured by the Discharge Readiness Inventory. Environments that demand too much autonomy in the home were associated with deterioration in the patient's community functioning. These results validate that the patient's perception of his or her fit with the environment is correlated with a successful adaptation to their living situation.

Hull and Thompson (1981a; 1981b) interviewed 296 individuals living in 157 board-and-care facilities in Canada to determine which patient and environmental factors "promote" the development of individual capabilities and increase the capacity of individuals to function adaptively in a community setting (1981b, pp. 248-249). These researchers found that environmental variables accounted for 57 percent of the variance in patient's community adaptation scores. For example, residents located near services in a community perform more effectively in a variety of skills as compared to persons in residences further away. Next, residences that provided integrated vocational, educational, recreational, and social activities were strongly associated with adaptive functioning, and the promotion of culturally

normative personal appearance and behavior. Also, it was important that a residence provide culturally normative autonomy and rights with regard to visitors, spending money, mail, and hours, and avoided overprotection and excessive rules. Respectful, courteous staff-resident interactions that promote residents' feelings of self-worth and dignity were preferred by residents.

Linn and associates (1977) studied patient characteristics related to environmental factors on social adjustment in 210 veteran males who were living in 150 different foster care homes and compared them to matched hospital controls. While foster care homes are usually transitional living situations, they provide a comparative model for community care homes. The major findings were that patients showed little or no change in social functioning, activity, mood, or adjustment due to hospital preparation for foster care. However, patients in foster care showed significant improvement within four months on social functioning and overall adjustment when compared to hospital care controls.

In further analysis of data from this earlier study, Linn, Klett, and Caffey (1980) examined characteristics of foster homes associated with improvement in social functioning in schizophrenic and non-schizophrenic residents. While patient characteristics did not predict differences in social adjustment, characteristics of the homes were associated with patient outcome. For example, the larger the home (i.e., more occupants) the more likely the patient was to deteriorate in social functioning. The presence of two patients or less in the home was related to patient improvement; more than two patients in the home

was correlated with no change or deterioration. The presence of children in the home was also significantly associated with improved social functioning regardless of diagnosis. Finally, manager-initiated activities were associated with improvement among nonschizophrenics and deterioration among schizophrenics. Thus residents differentially respond to environmental characteristics.

Patient satisfaction. Lehman and associates (1982a; 1982b) interviewed 278 randomly selected mentally disabled residents in 30 Los Angeles board-and-care homes concerning their perceived needs. Their responses to open-ended questions about their living situation and resources were examined. With regard to their living situation, most residents shared bedrooms (85%), were allowed visitors in their rooms (89%), could possess keys to lock their rooms (75%), and had access to television and a radio (90%). Issues that caused residents' dissatisfaction were staff controlling or changing T.V. stations and distributing mail. Residents desired greater safety in the homes but saw this as out of their control. Some efforts to improve safety within homes are desirable, but security efforts can carry their own costs in loss of autonomy, privacy, and freedom (Lehman, 1982a). Relocation of homes to areas with lower crimes and greater social stability might be considered. However, these authors concluded that such moves, if feasible, might meet with community resistance and could isolate patients further within their social environments.

In a more recent case study, Lehman, Possidente, and Hawker (1986) compared the quality of life of chronic patients in either community residences or state hospitals. The residents in supervised community

houses perceived their living conditions more favorably, had more financial resources, and were less likely to have been assaulted in the past year than state hospital patients. Thus, patient satisfaction and security, in general, is higher in community residences.

Discussion

Collectively, these evaluation studies have attempted to examine the influence of social environments on the behavior of patients who live in residential care facilities. Consistently, environmental characteristics such as facility size are better predictors of patient outcomes than are patient characteristics. These investigations reflect the assumption that association between the social environment (e.g., type of residential care facility) and patients' community functioning is a causal relationship. However, many questions remain about specific environmental variables and their relative contribution to outcomes in combination with other factors. Additional non-environmental factors that affect the patient's level of functioning include severity of illness and natural support systems (Sommers, 1988).

Overall, these studies contribute to our understanding of the great diversity of residential care facilities. In several studies, there was an association between smaller facilities (i.e., fewer residents) and resident satisfaction or involvement in the community. Also, the presence of supportive relationships, in combination with "not too high or not too low expectations" for social functioning seems to have a positive effect on patients. Thus, matching residents to

facilities on the basis of their ability to tolerate environmental stimulation.

In these studies of residential care, operators are considered part of the social environment. These studies primarily focus on residents' characteristics and outcomes. In Segal and Moyles' (1979) study, for example, residential care operators were only mentioned in terms of a variable called "management style." While these studies extensively examined patients in community environments, the perspective of the residential care operator was not considered. Also, while parallel research was developing on the effect of the emotional affect of family members on patient outcomes, it is surprising that the affective responses of significant persons who live with schizophrenics were not being examined. Given that there is a significant knowledge gap about the persons who operate these homes, further research is needed to examine the characteristics, perceptions and experiences of residential care operators.

Stresses of Psychiatric Caregiving

Family Caregiver Stress

Although little is written about residential care operators' stressors, the literature on family caregivers substantiates the stress associated with caring for a mentally ill relative at home (Creer & Wing, 1975; Grad & Sainsbury, 1963; Kreisman & Joy, 1974; Thompson & Doll, 1982). The family's response to mental illness has been a topic of concern since the mid-1950s. This literature made a gradual shift from viewing family members as an etiological factor in the patient's

mental illness to a more interactive approach that perceives them as reactors to the stress of caring for their relative (Kreisman & Joy, 1974). In part, the movement of care of mentally ill persons to community care has drawn attention to the difficulties experienced by caregivers (Goldman, 1982; Grad & Sainsbury, 1963; Platt, 1985; Test & Stein, 1978). Relevant reports document the psychological, social, and economic stressors experienced by family members who live with their mentally ill relative.

Collectively, the major findings of these family stress studies in Table 2.1, despite differences in sample size and methodology, were similar. The three major categories of stressors experienced by families were: (a) dealing with behavioral problems; (b) dealing with environmental stressors such as getting information about their relatives' illness and treatment, and dealing with neighbors and stigma; and (c) personal problems such as the lack of respite. The summary of the stressors experienced by families are included in Table 2.2

The family caregiving literature can give us insights into community caregivers since many of the functions traditionally performed by families are now performed by nonfamily members who care for and supervise residents in the community. Residential care operators may not only share common functions to the family but might also have similar concerns and similar stressors. Therefore, family care literature can give insights into the stressors of residential care operators. All of these studies corroborate that disturbing symptoms or behaviors are one of the greatest stressors for family caregivers. In the next section, some responses to symptoms will be discussed.

Table 2.1. Outline of Stressors, Concerns, and Problems Identified by Family Members

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments ^a
Grad and Sainsbury, 1963	410	Family caregivers	Structured interview	1, 2, 3, 4, 9, 10, 11, 14, 15, 17, 20	The problems that families complained of most often were not necessarily associated with mental illness. Behaviors such as restlessness, uncooperativeness, depressive thoughts, and complaints about physical symptoms caused the most stress.
Creer and Wing, 1975	80	Family caregivers of a self-help group and relatives randomly selected from a defined area of London	Survey of relatives of a self-help group and relatives randomly selected from a defined area of London	1, 2, 3, 4, 8, 9	Social withdrawal, underactivity, lack of conversation, few leisure interests, and slowness are described as the most common patient behaviors causing distress.

^aStressors, concerns, and problems are numerically coded on Table 2.2.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Kint, 1977	143	Family caregivers	Questionnaire	1, 2, 3, 5, 6, 9, 11, 13, 16	Family social and psychological burden were from patient problems such as social withdrawal, failure to consider the future, and suicide attempts. Families felt that they would benefit most from specific suggestions for dealing with difficult patient's behavior.
Hatfield, 1978	89	Family caregivers (parents, siblings)	Mailed questionnaires to 250 Schizophrenic Association of Greater Washington (self-help organization)	1, 2, 3, 6, 8, 9, 11, 14, 15	Focus of this study was to rate severity of stress provoked by disturbing behaviors and the effects of the person's illness have on others.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
El-Islam, 1982	540	Nuclear and extended family members of Arab adult schizophrenic outpatients	Case interviews	1, 2, 3, 7, 8, 9, 10	Relatives in extended families supervise patients' medications better and are more likely to tolerate behavior deviations, and allow temporary social withdrawal as compared to nuclear family members.
Thompson and Doll, 1982	125	Family caregivers	Survey using interview data: Freeman and Simmons' (1961) index of family members' embarrassment and incomplete Sentence Blank (1947)	1, 2, 3, 4, 10, 13, 14, 15, 17, 20	The emotional burdens experienced by families far outweigh the social costs (e.g., financial burden, disruption in everyday routines, or problems with neighbors).

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Rose, 1983	7	Family member as defined by the patient as being significant to him or her	Unstructured interviews of family members of first-admission patients	1, 2, 3, 5, 6, 16	The family member's perception of stigma affected decisions about who to contact for help and who they perceived were available to share their experience with.
Runions and Prudo, 1983	70	Family caregivers living with a schizophrenic relative	Structured questionnaire of problem behaviors	1, 2, 3, 7, 9, 10	Families focused on problem behaviors (e.g., negative symptoms) such as has few hobbies or friends, is underactive, or lacks initiative.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Anderson and Lynch, 1984	57	Family members (49% parents, 28% spouses, 6% male child, 17% siblings)	Mailed questionnaires (response rate 22%) Questionnaires on resources and stress (Holroyd, 1978) and the Family Environment Scale (Moses, 1974)	14, 15, 21	Findings suggest that the amount of contact with relative significantly correlated with less integration between the family members; family opportunities became more limited; there was a greater negative attitude toward the mentally ill relative; and the family reported less social support.
Potasznik and Nelson, 1984	56	Parents in self-help group for families of	Questionnaires of objective and subjective burdens	1, 2, 3, 4, 5, 6, 11, 12, 13, 14, 15, 18, 20	Major themes included lack of help from professionals in coping with under- standing the illness, treatment available, how to cope and how to live with the uncertainty of the illness. Parents felt alienated and criticized by professionals.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Gubman, Tessler, and Willis, 1987	345 family households and 622 other residential natives	Family households and other residential settings (e.g., group living situations)	Reports of case managers in 18 different community support programs sponsored by the National Institute of Mental Health	1, 2, 7, 8, 9, 10	Behavioral problems are the best predictor of complaints from all households regardless of type (i.e., temper tantrums and bizarre behavior). Families were most concerned with their relative's seldom socializing with friends, failure to perform household chores whereas in nonfamily residences, concern was with trouble with the law, destruction of property, inappropriate sexual behavior, wandering.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Hooley, Richters, Weintraub, and Meale, 1987	199	Spouses of schizophrenic and affectively disordered patients	Interviews	1, 2, 3, 9	Negative or deficit symptoms are more highly associated with marital discord as compared to positive symptoms.
Lefley, 1987b	not reported	Family members in numerous support groups	Summary of surveys, and participant observation in numerous family support groups	1, 2, 3, 5, 6, 9, 10, 13, 14, 15, 18, 20	The family's experience of objective burdens include: patient's ongoing dependency and inability to fulfill expected role functions. Subjective burdens include grief, empathic reactions to the pain of a loved one.

Author and Date	Sample Size	Subject Characteristics	Data Source	Stressors, Concerns, and Problems	Comments
Moh and Turner, 1987	211	Spouses (n=163) and parents (n=48)	Structured questionnaire of behavioral problems	1, 2, 3, 9	Problem behaviors include noisiness and wandering at night, uncooperativeness, too dependent, expressing unusual or unreasonable ideas, and speaking and behaving oddly.
Chafetz and Barnes, 1989	20	Family caregivers of schizophrenic (19) or bipolar disorder (1)	Semi-structured interview that also allowed subjects to spontaneously state three important problems	1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 15, 17, 18, 19, 20	The most distressing problems involved dealing with the mental or emotional state of the patient.

Distressing behavior. Thompson and Doll (1982), in their study of families, identified problems with the emotional state of the disabled relative, including depression, anger, and psychotic symptoms. Mood and feelings caused the greatest distress in these families, far greater than performing concrete tasks for their mentally ill relative. Similarly, the most frequent problem identified in other studies of family caregivers involved the emotional or mental state of their mentally disabled relative (Chafetz & Barnes, 1989). Thus, coping with the patient's disturbed mental state was a major concern for families. Although families displayed a high level of tolerance for deviant behaviors, the stress experienced was substantial.

Families reported distress with both positive and negative symptoms. Florid, or acute, psychotic symptoms have been reported as distressing, especially at the time of discharge when the patient is acutely symptomatic (Grad & Sainsbury, 1963). Delusions and hallucinations may be frightening to family members (Lefley, 1987a; 1987b). Families, however, also report feeling distressed with negative or deficit symptoms of their relative. In fact, several studies suggest that over the long term, families express more concern with passive or socially withdrawn behaviors than with positive symptoms (Creer & Wing, 1975; Hoenig & Hamilton, 1966; Hooley, Richters, Weintraub, & Neale, 1987; Kreisman, et al., 1988; Lefley 1987a; Runions & Prudo, 1983).

An explanation of families' frustration with a patient's lack of motivation and initiative is perhaps due to the belief that these behaviors are volitional and thus within the control of the mentally ill

Table 2.2

List of Problems Identified in the Literature for Family Members

-
1. Problems with emotional or mental state.
 2. Problems with behavior (e.g., bizarre, threats of violence or self-harm, socially embarrassing).
 3. Problems with the communication ability of the mentally ill relative.
 4. Problems with physical condition (e.g., somatic complaints).
 5. Unpredictability of the outcome or course of the illness.
 6. Uncertainty and concern about the future of their family member.
 7. Problems monitoring medications.
 8. Problems monitoring self-care (activities of daily living).
 9. Problems with negative symptoms of lack of motivation, passivity, apathy, and anhedonia.
 10. Need for close and ongoing supervision.
 11. Insufficient ability to cope with patient's difficult behavior.
 12. Insufficient information to care for patient.
 13. Lack of respite from demands of caregiving.
 14. Restriction of social and leisure activities.
 15. Interference with other responsibilities in life, such as work and relationships with other family members.
 16. Stigma of living with a mentally ill person.
 17. Problems with neighbors.
 18. Criticisms by professionals.
 19. Inadequate housing.
 20. Financial pressures.
-

Adapted from J. Norbeck, L. Chafetz, S. Weiss, & H. Wilson (1985).

relative, whereas "positive" or acute symptoms, because they are expected characteristics of the illness, are perceived as legitimate by the caregivers.

El Islam (1982) found that extended families were more tolerant and less intrusive when patients had brief periods of protective social withdrawal. Thus, the extended family was less likely to tax the patient's limited social capabilities as compared to the nuclear families in this study. A plausible explanation of the El-Islam study is that the nuclear family differs from the extended family in its more intense emotional commitment to their relative, and thus is more invested in the patient's change while the extended family was more accepting of the patients withdrawal, and this resulted in more benign outcomes. These differential findings about family type raise questions about how residential care operators respond to symptom-related behaviors in clients.

Residential Care Operator Stress

The only published survey of residential caregivers was conducted in San Francisco by Blaustein and Viek (1987). Seventy-four operators responded to mailed questionnaires about their concerns and problems. Like family caregivers, they experienced stress regarding living with and managing distressing client behaviors. Also financial problems were mentioned with regard to running a business. Problems unique to residential care operators were: problems with unreasonable licensing requirements and criticisms by the media.

Mediating Caregiver Stress

Although coping and social support have been identified as mediators of stress, only three studies of family caregivers who live with an adult mentally ill relative were found that explored these variables (Noh & Turner, 1987; Norbeck, Chafetz, Skodol-Wilson, Weiss, 1991; Potaznick & Nelson, 1984). These studies demonstrate mixed results. A family caregiving study by Potaznick and Nelson (1984) of parents of schizophrenics ($n=56$) in a self-help group demonstrated a significant correlation between satisfaction with the quality of social support received from network members as measured by the Social Network List (Hirsch, 1979; 1980) and the degree of burden and stress experienced by family members. In contrast, however, another multivariate study of family caregivers (e.g., spouses =163; parents=48), Noh and Turner (1987) found burden in parents and spouses was significantly correlated with mastery or sense of personal control as measured by the Revised Kaplan Scale (Turner, Frankel, & Levin, 1983), not social support.

Descriptive analysis of data from a larger family caregiver study by Norbeck, Chafetz, Skodol-Wilson, and Weiss (in press) noted that some caregivers were socially isolated and had restricted and dense networks that first turned to the family network for support (Chafetz & Barnes, 1989). In addition to family members, caregivers in this study reported the need for contact with peers who also had experience with a psychiatrically disabled relative.

The findings of the family studies and the residential care operator study are outlined in Table 2.1. These studies provide a

tentative list of possible concerns and problems to be studied (see Appendix A). While these studies provide information about family caregivers, and while they identify variables that may be relevant in study of mediators and stresses, their findings may not be generalizable to residential caregivers or pertinent to their specific needs. Replication of studies such as these with residential care operators will add to our knowledge of social networks and support needs in this group of paid nonprofessional caregivers.

Summary

In summary, previous work has primarily described stresses experienced by family members who live with a schizophrenic relative. While this literature gives insights into caregiver stress, it applies to relatives of the mentally ill. Many of the functions traditionally performed by families are also performed by nonfamily members who provide the interpersonal and physical living environments for mentally ill persons in the community (Gubman, Tessler, & Willis, 1987). Because residential care operators have responsibilities for caregiving, they also need to be studied.

Residential Care Operator Role

Roles, such as that of a residential care operator, can be a source of stress. The term role refers to both the expected and the actual tasks and behaviors associated with a position. Roles, such as the residential care operator's role, are socially structured with expectations. For example, the tasks of residential care operators are

regulated by many different agencies. However, little is known how residential care operators actually interpret and perform their roles.

Litwak (1977; 1985) proposes a model for understanding tasks performed for persons by either their family (e.g. primary group) or professionals (e.g. formal organizations). According to Litwak, the primary group, such as the nuclear family, on the basis of everyday contact, have clearly defined commitments to care for the emotional needs of its members. Primary group members have noninstrumental relationships where the relationships are an end in itself. They meet in continual face-to-face contact, and their actions are motivated by internalized altruistic feelings, whereas formal organizations are more impersonal and concentrate on technical knowledge and high specialization of tasks. Formal organizations are oriented toward maintenance and continuation of the viability of the organization through incentives such as economic rewards.

Litwak (1985) provides a model continuum to understand the degree to which persons in primary groups perform tasks associated with certain roles. Table 2.3 depicts primary groups and types of tasks provided. The nuclear family and formal organizations are at opposite ends of the continuum. Residential care operators have been placed between the nuclear family and formal organizations in Table 2.3 for the purpose of this discussion.

A number of hypotheses may be proposed concerning possible role dimensions of residential care operators. Although, the enactment of the role is highly speculative and must be confirmed by empirical data. For example, high face-to-face contact or continual proximity would more

Table 2.3

Different Primary Group Structures and Tasks

Types of Primary Groups			
Task Dimensions	Nuclear Family	Residential Care Operators	Formal Organizations
Size	Smallest	?	Very large
Face-to-face contact of group	High	?	Low
Affection	High	Variable	Lowest
Long-term commitments	High	?	Lowest
Degree of specialized skills	Low	?	High
Illustrations of Services that Match Dimensions in Columns Above			
	Daily cooking, shopping, house-cleaning, laundry	Daily cooking, shopping, house-cleaning, laundry	Continuous care provided by many specialists for a limited time

Adapted from Litwak, E. (1985). Helping the elderly: The complementary roles of informal networks and formal systems. New York: The Guilford Press.

likely occur in a small home. Family members have long-term commitments to their members that are generally motivated by internalized, altruistic feelings, and a sense of duty to group survival (Litwak, 1985). Although residential care operators may have more intense personal relationships over time than staff who work in formal organizations (e.g., hospitals), their degree of long-term commitment would most likely not be as high as the nuclear family. While families are considered to be high in affection, individual residential care operators would probably vary on this emotional task. The degree of specialization of tasks in smaller residences would resemble the nuclear family than institutions. However, large residential care facilities with many residents may perform tasks in a highly specialized role function similar to formal organizations. The day-to-day domestic tasks such as housekeeping, cooking, clothes washing, and personal hygiene performed by residential care operators would also be similar to nuclear families. These comparisons are based on speculation. To my knowledge, there is no descriptive data concerning how residential care operators view their roles.

Role Strain. Role performance can be problematic when expectations are conflicting and the norms are vague. Role strain is defined as a subjective state experienced by a person in response to social situations in which role obligations are vague, difficult, conflicting, or impossible to meet. Residential care operators are neither primary group members nor professionals who work in formal organizations where their role would have relatively clearly defined expectations. Rather their roles are poorly defined, with possible

diverse and contradictory goals. Generally, three types of role strain may occur: role ambiguity, role demands, and role captivity.

Role ambiguity. Role ambiguity, which occurs when the norms for the role are vague or unclear (Merton & Barber, 1976), may be particularly detrimental to residential care operators. Ambiguity may arise from not being either family or professionals. Residential care operators, for example, may work under vague directives with little or no preparation for the expectations of the role. For example, a potential area of ambiguity is in giving medications to residents. Most operators are not trained or educated about how to administer medications; however, they are held responsible for giving the correct medication and dosage, monitoring the resident's response, and making decisions about when professional consultation is necessary concerning medications.

Another source of ambiguity for residential care operators is that their role status is poorly defined. Litwak (1985) describes the tasks of primary groups and formal organizations. The primary group, such as family, on the basis of everyday contact, have relatively clearly defined commitments to care for the emotional needs of its members, whereas formal organizations and health care professionals have clearly defined tasks. Residential care operators do not fit into either group. Thus, ambiguity concerning their caregiving role may create strain.

Role demands. Roles may have societal expectations at particular times and places that are not congruent with the individual's interpretation of the role (Goode, 1960). Role strain may be experienced, therefore, when the individual's perception of whether he

or she is receiving rewards is not commensurate with his or her effort. These strains are often associated with the person's occupational role and family.

Role strain may occur when work is imposed by others, especially persons in authority, and not self-generated (Pearlin, 1983). Strain is dependent on the person's perceived discrepancy between the demands of the task and the level of reward. State licensing regulations, inspections, and community mental health requirements are important. However, oftentimes, regulations that impact residential care are decided at the state and county level without communication and input from the operators. Thus, residential care operators experience downward communication without negotiation or input.

Role captivity. Role captivity occurs when the individual perceives an inescapable obligation to be and do one thing while at the same time desiring to do something different (Pearlin, 1983). It is this feeling that no escape route exists that triggers conflict. Entrapment can be more stressful for those persons who do not have a lot of options.

Although not all of these role strains may occur, they offer an explanation of possible conflicts and confusion experienced in residential care operators' enactment of their roles. Additionally, in part, they explain how residential care operators "fall between the cracks." They do not have the legitimacy of professionals or clearly defined commitments of the family.

Coping with Role Strain

Making choices, or the process of negotiation of roles, is used by

the individual to resolve role strains. Goode (1960) proposes individuals continuously make choices between alternative role behaviors in order to reduce their role strain. The time and energy, that a person is willing to put into the role, is determined by the person according to their beliefs, values, and commitments. Some roles have higher commitments than others.

Factors that are likely to influence choices of roles are commitment to the system or role, rewards associated with the relationship, interpersonal and economic costs, required effort, and energy, available time, and personal interest (Goode, 1960). Thus, persons set priorities for enactment of roles. Goode enumerates techniques used by persons to reduce their role strain: compartmentalization, delegation, elimination of role relationships, role expression, and insulation.

Compartmentalization, or making sharp distinctions between different roles, for example, may be useful in managing role strain. It could be hypothesized that separating work outside from personal lives at home could relieve role strain. It is unknown as to how residential care operators, who live in the home where they work, manage the separation from or the integration of their caregiving role with their personal lives. Do they see a merger of their private lives with their work or are they able to establish boundaries?

Conceptual Framework: The Caregiver Stress Model

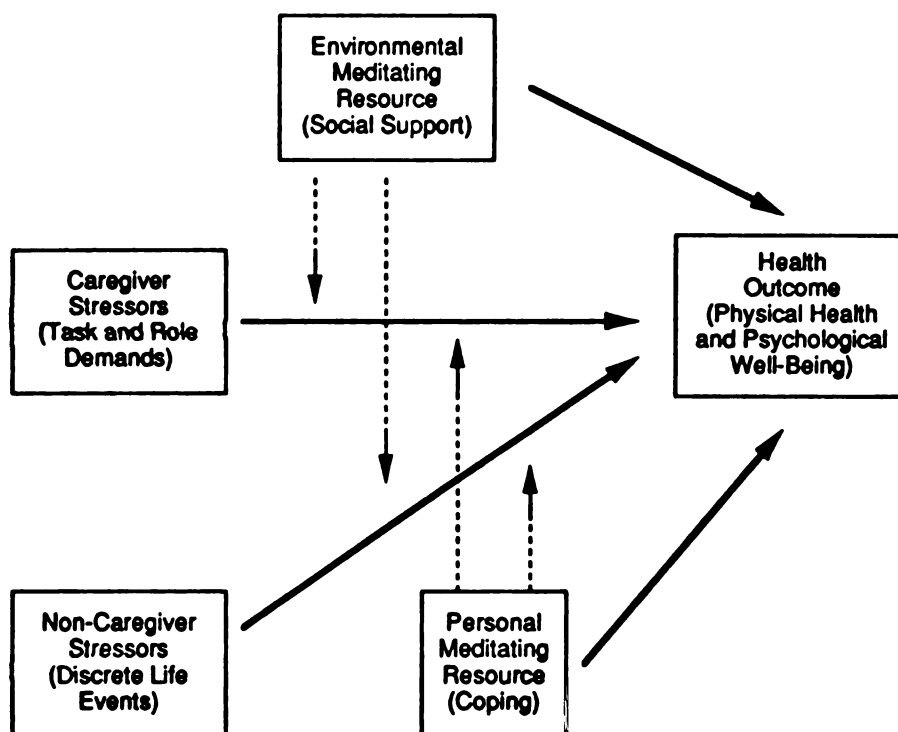
The caregiver stress model (Figure 2.1) provides a basis for the examination of the interrelationships among the major concepts of this

study. These concepts include various sources of stressors, personal and environmental resources that may mediate the impact of stressors and effect subsequent outcomes.

Stress

Lazarus and Folkman (1984), in their transactional theory of stress, view the person and environment in a dynamic, reciprocal, multidimensional relationship. Stress is defined as a relationship between person and environment which is appraised as taxing or exceeding one's resources and threatening well-being. Thus, within this model, whether an event is experienced as stressful or not stressful is based on the individual's evaluation; this evaluation process that the person engages in is called cognitive appraisal. Cognitive appraisal is the process of categorizing a situation, and its various dimensions, with respect to its impact on well-being. Thus, the person evaluates situations in the environment with regard to their personal relevance and significance.

Lazarus and Folkman (1984) divides the appraisal processes into primary appraisal and secondary appraisal. These two appraisals occur simultaneously and interact with each other in determining the degree of stress experienced and the response to the stress, or emotional reaction. Primary appraisal is a cognitive process, which determines what is at stake in the situation and whether the person perceives the event as positive or threatening. Secondary appraisal is another cognitive process where the person evaluates possibilities and constraints that are available for dealing with the situation. It involves the way a person copes with a stressful event, including the



The direct effects are represented by solid lines;
mediating effects are represented by broken lines.

Figure 1. Caregiver Stress Model

person's decisions, actions, interpretations, and search for help. Primary appraisal refers to three ways in which a situation is evaluated to be irrelevant, benign-positive, or stressful. If the event is irrelevant, it has no implications for the person's well-being and adaptive functioning continues. If the event is benign-positive, it preserves adaptive functioning or enhances well-being. If the event is perceived as stressful, then its meaning can be categorized into three subtypes: harm or loss, threat, or challenge.

Personal and environmental resources can act as mediators in reducing the impact of stressors. How a person perceives available resources will help him or her cope may determine the outcome of a stressful situation. These resources can be attributes of the person or of the situation. Coping is a resource of the individual. Social support is an environmental resource.

Coping

The person's sense of resources, possibilities, and constraints represent the way a person copes with a stressful event (Lazarus & Folkman, 1984). Coping consists of the person's cognitive and behavioral efforts to manage a situation appraised as stressful. Two major categories of coping strategies are offered in this transactional theory of stress. Coping responses, as theorized by Lazarus and Folkman (1984), constantly change and are categorized as problem-focused or emotion-focused. Problem-focused coping strategies are aimed at changing or ameliorating the stressful situation. It deals directly with the source of the stress by changing one's own behavior or changing environmental conditions. Emotion-focused coping is directed at

reducing emotional distress and may include cognitive strategies such as denial, avoidance, intellectual detachment, and other interpretative efforts to modify the meaning of the situation.

Further, Lazarus and Folkman (1984) discussed a cognitive process of coping called cognitive re-appraisal that occurs in either problem-focused or emotion-focused coping. Re-appraisals of the situation may occur at any point in the coping process, resulting in a changed appraisal about how an event is perceived, as a loss, threat, or challenge without changing the actual event. Thus, stress and coping are dynamic, ongoing processes that are open to change based on the person's perception. Factors that influence primary and secondary appraisal are categorized as personal factors and situational or environmental factors.

Person factors include the person's history and characteristics, and account for individual variations in appraisals of stress and coping (Lazarus & Folkman, 1984). Person factors include past experience, commitments, and beliefs. Past experiences, commitments, and beliefs influence appraisal by (1) determining what is salient for well-being in a given situation; (2) shaping the person's interpretation of the event in his or her coping efforts; and (3) providing a basis for evaluating outcomes. Thus, background meanings not only determine what is experienced as stressful, but also what coping options are available to the person.

Situational factors include the context or properties of the event that determine how appraisal processes are shaped. The same event does not affect each person in the same way. Situational factors that affect

the person's perception of the event with regard to stressfulness are novelty or the degree to which the person is unfamiliar with a situation, uncertainty that an event will occur or not, and, temporal factors of imminence, duration, and ambiguity.

Other people or social support is another situational factor which affects appraisal. This study examined social support as a relevant transactional variable. In a transactional model, it is not the presence of social support alone that reduces stress, but the person's commitments and beliefs about relationships, or other people, that influence support.

Social Support

Recent research suggests that social support may buffer the impact of stress, especially in its influence on the well-being of family caregivers (Baillie, Norbeck, & Barnes, 1988; George & Gwyther, 1986). There is considerable evidence that the quality of an individual's interactions with family, relatives, friends, and co-workers can have health-protective and possibly health-promotional benefits (Gottlieb, 1981). House (1981) proposes a model of how social support promotes health and reduces stress. Without social support, stress can have a direct negative impact on health (arrow d). Schematically, Figure 2 depicts three ways how support works.

First, in Figure 2.2, social support can directly reduce stress (arrow a). An explanation of this direct effect of social support on stress relates to cognitive appraisal (Cohen & McKay, 1984). Support by others may redefine and reduce the potential threat posed by a situation and thereby prevent the appraisal of a situation as stressful. Second,

support can directly enhance physical health and psychological well-being (arrow c) due to its provision of basic human needs for affection, affiliation, security, and social connectedness (House, 1981).

The stress-buffering hypothesis, as represented by arrow b in the model, provides an explanation of how social support protects people from the harmful effects of stress (House, 1981). This hypothesis proposes that the impact of stress on health is stronger under conditions of low support than of high support (Cohen & McKay, 1984). In other words, support and health are more strongly related under conditions of high stress than of low stress.

House (1981) describes how support may buffer the impact of stress. He suggests that support may affect the person's perception of the situation so that it seems less stressful, and it may tranquilize the neuroendocrine system to decrease the person's reactivity to the perceived stress (Cassell, 1976), or it may facilitate self-care health behaviors such as exercising or attending to personal hygiene, proper nutrition, and adequate rest. Although the buffering hypothesis asserts that support exerts beneficial effects in stressful situations, the underlying mechanisms of how support operates as a buffering process needs further explication.

The most common proposition of how support works is that it facilitates coping (Cobb, 1976; Cohen, 1988; Cohen & McKay, 1984; Heller & Swindle, 1983; Heller, Swindle, & Dusenbury, 1986; Thoits, 1986). Significant others assist with stress management by assisting the person to change the situation, to change the meaning of the situation, to change one's emotional reaction to the situation, or change all three

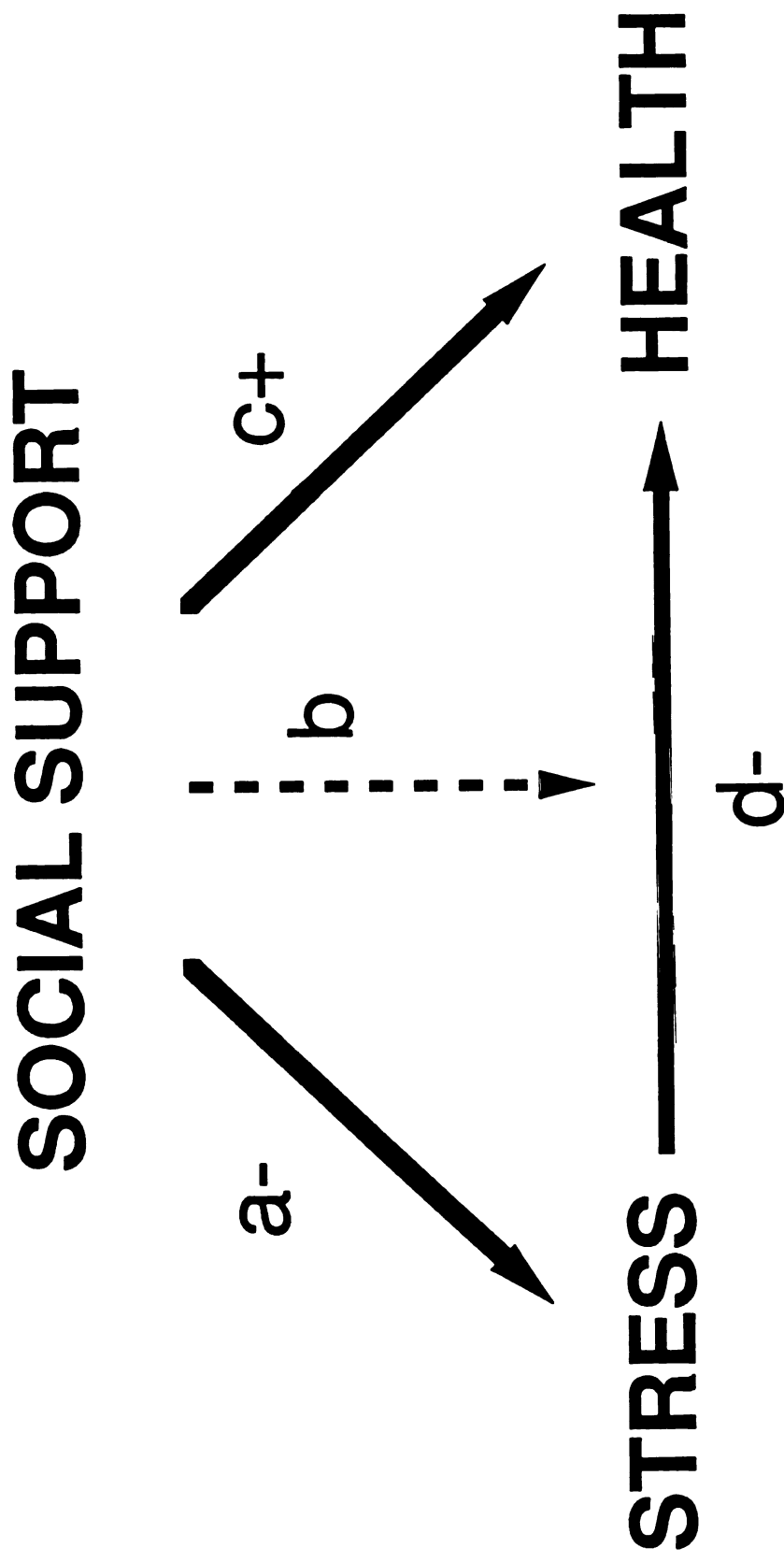


Figure 2.2 Simplified conceptualization of social support, stress, and health.
From Norbeck, J. (1988). Social support. Annual Review of Nursing Research, 6, 87.

(Thoits, 1986). This is done by suggesting alternative strategies or by participating directly in an individual's coping efforts.

Cohen (1988) postulates that social support operates through four psychological processes. First, social network ties provide multiple sources of information that can give appropriate advice to promote health behaviors or provide stress-buffering information resulting in benign appraisal of stressful events or enhancing ability to cope with stressful events or their emotional consequences. Second, social support, through social integration, gives a sense of identity and an evaluative basis for a sense of mastery resulting in increased self-esteem and perception of control. Third, social controls and network pressures promote learning of particular modes of coping with stressors. Lastly, networks provide aid and tangible services resulting in benign appraisal of stressful events. Thus, the presence of supportive others affects the person's subjective appraisal of events that facilitates averting a potentially stressful situation or enhances ability to cope with stressful events.

Little is known about residential care operators' social support systems. Several factors may make residential care operators at risk for limited social support resources. The social stigma of living with mentally ill persons as described in the literature may have negative consequences such as causing alienation from neighbors and potential friends (Tessler, Killian, & Gubman, 1987). However, since no literature describes the social support structure and function of residential care operators, research in this area of support resources is needed.

In summary, social support and effective coping are reciprocal and interactive. To successfully gain necessary social support, a person must have the skills to recognize and cope with social demands, as well as be able to recognize and use available social resources (Lazarus & Folkman, 1984). Further, it is known that both coping responses and social support are dependent on specific situations. Coping responses were found to be consistent with the type of stressor. For example, McCrae, (1984) found that given three separate stressors of a loss, a threat, and a challenge, the type of stressor had a significant effect on the choice of coping mechanisms. Further, for example, marital status may affect the type of and sources of support needed to deal with work stress (Norbeck, 1985). Thus, research must consider aspects of the person as well as specific situational factors in relationship to the person's coping response or support needed.

Health

The transactional cognitive theory of stress proposes that the perception of somatic health and psychological well-being is related to the way people appraise and cope with stress. Thus, the greater the perception of stress, the lower the perceived health status. I have accepted the World Health Organization's definition of health as including physical, psychological, and social well-being (WHO/UNICEF, 1978). Opinions, however, vary in terms of how to objectively document and measure the physical and psychological correlates of health. Most research on health is based on what a person reports about their perceived health (Lazarus & Folkman, 1984). It is important for respondents to indicate how they view their own health and how they

evaluate or feel about that information. Therefore, two dimensions of health were considered in this project as being related to the process of coping: somatic health and psychological well-being.

Research Questions

1. What are the demographic characteristics of this sample: the characteristics of the homes and the personal characteristics of the residential care operators?
2. How do residential care operators perceive their role and what are their perspectives on their work?
3. What are the major stressors of residential care operators?
4. What coping strategies do residential care operators use for specific types of stressors?
5. What are the types and sources of social support identified by these subjects?
6. What are the support needs identified by these subjects?
7. What specific factors are associated with social support, such as personal and demographic characteristics of the residential care operator and facility characteristics?
8. What are the associations among stressors, social support, somatic health, and psychological well-being?

CHAPTER III

METHODOLOGY

The methods and procedures used to collect and analyze the data in this study are discussed in this chapter. A qualitative methodology is appropriate for understanding and describing complex psychological and social phenomena, such as stress, coping, and social support. Due to their subjective nature, these phenomena can only be measured indirectly, based on reports of the person experiencing them. A fundamental assumption in qualitative research is that the subject's perspective on the phenomena of interest should unfold as the subject views it, not as the researcher views it (Marshall & Rossman, 1989). Thus, questions were asked to elicit the subjective experiences of residential care operators to better understand their perceptions, feelings, and beliefs. This discussion is divided into six sections: the design, the sample and setting, the data collection method, data collection procedure, data analysis, and human subjects assurance.

Design

This was a descriptive design used to investigate the stressors, coping strategies, and social supports of residential care operators. Cross-sectional data were obtained by two data collection methods, an in-depth, focused-interview schedule and standardized questionnaires. These two data collection strategies were used to examine the complex phenomena of the study and provide cross validation of the findings. The interview was designed to obtain rich descriptive.

A cross-sectional design was selected to obtain data at one point in time. Although cross-sectional design has limitations (e.g., it does not study process), it was selected for this study's design for a number of reasons. First, the problem of gaining initial access to this population was a major consideration. Residential care operators have busy schedules and are involved in client-related activities (e.g., taking clients to scheduled appointments) and in maintaining their homes. Second, because they are constantly monitored by numerous licensing and mental health personnel, they are selective about whom they invite into their homes. Because of these factors, studying subjects who would be willing to engage in a study would introduce a significant sampling bias. Those subjects who might agree to participate in repeated contacts might be a unique subset of residential care operators. Therefore, longitudinal design might result in the under-representation of other segments of residential care operators. Thus, a cross-sectional design was chosen to obtain a more diverse sample that reflects the variability that may exist in the population of residential care operators.

Description of the Sample and Setting

This study was conducted in two Northern California counties. Interviews were conducted in the homes of residential care operators who were licensed by Community Care Licensing, Department of Social Services in the State of California. Residential care operators were identified through computerized directory reports published by the State of California.

A theoretically based rationale guided the choice of these counties. The two Northern California counties were selected because they more closely represented the types of neighborhoods and homes in which the majority of sheltered-care facilities were located in the statewide study by Segal and Aviram (1978). In Segal and Aviram's sample of 1,155 sheltered-care facilities, the majority were located in suburban neighborhoods (44%) and were in single family homes (37%). Thus, by selecting these primarily suburban counties, an attempt was made to increase the representativeness of the sample, thereby increasing the generalizability of the findings to the larger population of residential care operators. Also, in order to select a specific type of residential care operator that may be comparable to a family-type environment, operators who shared living environments with their clients were chosen for this study.

Sample Selection

A convenience sample was drawn from a list of all known licensed residential care facilities in two Bay Area counties. In these counties, there are approximately 220 licensed residential care facilities for adult mentally ill persons listed in computerized directories (State of California, Department of Social Services, Community Licensing Division, 1990). The number of facilities was determined by counting the number of facilities that were categorized as licensed for ambulatory adults from ages 18 to 59.

Community Care Licensing in the State of California defines "Adult Residential Care Facility" broadly to include listings of adult

residential care facilities for not only mentally ill individuals but also for developmentally disabled individuals and other adult care facilities. Because the State of California does not differentiate specific subcategories of Adult Residential Care Facilities in their statewide statistics, it was necessary to consult with clinicians in agencies to verify which facilities were licensed for mentally ill clients and met the sample selection criteria.

Criteria for Sample Selection

The selection criteria for inclusion in this study include persons who: (1) were licensed by the Department of Social Services, State of California, to operate an adult residential care facility for mentally ill persons between the ages of 18 to 59 years; (2) lived in the home and assume primary responsibility for providing patient supervision in areas including activities of daily living, maintaining the interpersonal and physical environment, and distribution of medications; (3) were financially reimbursed for his or her work with residents; (4) had been in this role for a minimum of 6 months; and (5) operated a home with more than two and less than fifty residents. The Directory of Community Care Licensing of Licensed Residential Care Facilities (State of California, 1990) provided the list of all licensed operators of adult residential care facilities. In consultation with clinicians who work directly with licensed operators, potential subjects who met the study criteria were identified. As the result of this selection process, of the 220 potential licensed residential care operators, the 120 subjects who met the criteria were sent study introduction letters.

Process of Recruitment

The introduction letter described the nature and purpose of the study (Appendix A). It was essential to explain to the subjects that neither this research nor the investigator was associated with licensing or any other governmental agencies and to assure subjects of anonymity and confidentiality. After one week, the residential care operator was contacted by telephone to answer questions about the study and arrange a convenient time and place to meet for the interview protocol. As the study proceeded, by a "snow-ball" effect, subjects who participated in this study recommended potential subjects from their personal and professional networks.

Attrition

Although many operators expressed an interest in participating in this study or in knowing the study's findings, a variety of factors precluded their participation in this study. Table 3.1 shows that twenty-five percent of these potential subjects could not be contacted by either letter or phone. Another eleven percent of this group had changed their licenses from caring for mentally ill to developmentally disabled or elderly, and thus were no longer met the selection criteria.

Of the seventy-seven residential care operators who were contacted, thirty-seven did not participate. The most common explanation given for refusal to participate was time constraints. Time required for home maintenance, licensing requirements, and client-related appointments were some of the reasons given. Other nonparticipants gave personal reasons for refusal such as illness, two were having chemotherapy treatments. Several potential subjects openly

expressed their concern about how the findings of this or any other study might be used to continue the myths about residential care. Some noted, that giving access to the media has resulted in further misrepresentation and inaccurate reporting about homes. Distrust and suspicion of licensing, professionals, and governmental agencies was also mentioned. Therefore, of the 120 residential care operators who were sent letters inviting them to participate, 77 were contacted, and 40 subjects or 52 percent consented to be interviewed. Once the interview had begun, all interviews were completed. No interviewed subjects were excluded from the analysis.

Data Collection Methods

Data were collected by using a structured interview schedule and several closed-item questionnaires. The interview schedule contained demographic and background questions, and open ended items about stressors, stress-specific coping strategies, social support, and health. Questionnaires included the Caregiver Stress Questionnaire, Norbeck Social Support Questionnaire, Somatic Health Questionnaire, and the Bradburn Morale Scale. The study concepts, measures, number of items, and the amount of time each component required are listed in Table 3.2.

Interview Schedule

The focused interview schedule provided a guide to elicit rich, detailed information for the qualitative analyses. The goal of the focused interview was to discover the informant's experiences concerning

Table 3.1

Information about Participation in Study

Explanations for Participation	Number of Residential Care Operators with Percentages ^a	
Unable to Contact		
Letter returned	2	(2%)
Telephone call unanswered	28	(23%)
Did Not Meet Criteria When Contacted	13	(11%)
Contacted		
Refused: Time constraints	22	(18%)
Refused: Not interested	6	(5%)
Changed Mind	9	(8%)
Agreed to participate	40	(33%)
Total Residential Care Operators Who Were Interviewed	40	(52%) ^b

Note. ^a The number of operators represents those operators ($n=120$) who were sent study introduction letters.

^b Percentage of total participated is based on the number ($n=77$) of operators contacted.

their role, stressors, coping strategies, and social supports. The interview schedule included the following sections:

Interview Introduction

The interview began with an introduction to the study and consent form (Appendix B). A brief discussion of the purpose of the study was given to residential care operators as follows: to determine the major stressors or concerns in their job and what things and persons help them deal with these specific stressors. Then, as the beginning question, an open-ended question was asked: "Would you tell me how you happened to get into this business?"

Demographic Information. Demographic information questions elicited information about personal background of the subjects on age, gender, marital status, children, number of staff, number of hours worked, experience in residential care and membership in organizations and programs for residential care operators (see Appendix C).

Description of the Residential Care Setting. The items in this section of the interview elicited background information about the home environment such as the number of beds, location of the home, type of neighborhood, appearance of the home, home rules, and whether family or friends visit residents in the home (Appendix D).

Caregiver Stress Interview. This interview protocol developed by Gottlieb (1978) and adapted by Norbeck, Chafetz, Weiss, and Wilson (1985) was used to identify caregiver stressors, perceived available social supports, and coping strategies. The caregiver was asked "to think about your role as a residential care operator and tell me about any important problems which you are experiencing and which concern

Table 3.2

Data Collection Strategies

Concept	Measure	Number of Items	Time ^a
	Part I:		
Background	Demographic Information	14	5
	Part II:		
Physical and Social Environment	Description of Residential Setting	24	5
	Part III:		
Social Support	Support for Highest Ranked Stressors	18	10
	Norbeck Social Support Questionnaire	13	10
Stress	Stress of Caregiving	25	10
	Experience with Caregiving	8	5
Coping	Coping with the Highest Ranked Stresses	36	15
Somatic Health	Health Questionnaire	11	5
Psychological Well-Being	Bradburn Morale Scale	11	5
	Total		70

Note. ^a Time in minutes was the approximate time required of subjects to complete the instrument.

you." The subjects initially were asked to list three stressors or problems with regard to being a residential care operator. This section allows the subject to identify three stressors that come to mind without prompting. These stressors were recorded on the Caregiver Stress Questionnaire.

Caregiver Stress Questionnaire. Using a modification of the Norbeck et al. (1985) protocol, the residential care operator was asked to rate the severity of stressors on the Stress of Caregiving Questionnaire (Appendix E), using a 7-point Likert Scale, three problems identified by the subject, and 22 pre-established problems identified in the family and residential care literature and summarized in Appendix E. The content of the pre-established items included clients' behaviors, personal consequences of caregiving, and environmental stressors including dealing with mental health professionals, financial, and licensing regulation issues. The subjects were asked to rate each item on a 7-point scale ranging from no stress to high stress. Then the subjects were asked to select their three highest ranked stressors from the total 25 items so that these highest ranked stressors could be discussed in depth in the specific coping and social support section of the interview.

Highest Ranked Stressors, Specific Coping, and Social Support.

The three highest ranked stressors from the Caregiver Stress Questionnaire were used for more in-depth questions about coping and social support. In the interview schedule, this was called "Dealing with the most Stressful Problems" (Appendix F). This section allowed in-depth exploration of coping and social supports used by subjects to

work with the three stressors ranked as the most severe. The coping and social support questions were repeated in the same sequence for each of the three highest ranked stressors.

Coping with the Highest Ranked Stressors. The coping section includes questions describing strategies for each of the three highest ranked stressors. The subjects were asked how they dealt with each of the stressors. If additional guidance was necessary, the probes in the interview were used to assist in identifying the coping strategies.

Social Support for Highest Ranked Stressors. For each of the three highest ranked stressors the social support items explore subjects' perception of their available supports. For each stressor they were asked to identify a person or persons who were most helpful in dealing with each significant problem, to explain this person's relationship to them, and to describe the type of support they received.

Experience with Caregiving. Experience with caregiving was elicited with eight open-ended questions about how residential care operators perceive their roles and available resources (Appendix G). Open-ended questions were asked about (1) advice that they would give new operators going into this business; (2) important things for them to know in this work; (3) what they would change; and (4) if they planned to stay in this job as a residential care operator. These open-ended questions elicited responses to identify beliefs about work and perceptions of the role as subjectively perceived by the residential care operators.

Additional probes were asked about available and needed support in the following areas: (1) the resources and supports they would turn to

when they had difficulties; (2) who helps in an emergency such as a patient crisis; (3) what are additional support resources; and (4) what support they recommend. Subject responses from this portion of the interview were used in the support need section of the qualitative analysis.

Standardized Questionnaires

Norbeck Social Support Questionnaire

The Norbeck Social Support Questionnaire (NSSQ) (Appendix H) is a self-administered questionnaire designed to measure perceived support based on Kahn's (1978) three functional components of social support: affect, affirmation, and instrumental aid (Norbeck, Lindsey, Carrieri, 1981; 1982; Norbeck, 1984). First, the subject was asked to list a maximum of 24 members of their personal network and to identify the type of relationship. Then, each network member was noted on eight questions with a 5-point Likert scale: (1) six questions measure affect, affirmation, and aid; and (2) two questions measure the duration of relationship and frequency of contact. Finally, an aspect of the concept of convoy was measured by changes (e.g., loss of relationships due to moving, a job change, divorce or separation, death, or some other reason) that had taken place within the subject's social network during the past year.

The scores from the NSSQ form nine subscales which are combined to form three main variables. A brief description of the three main variables is as follows: (1) Total Functional is a sum of the three functional subscales affect, affirmation, and aid; (2) Total Network

Properties is a sum of the number of members listed in the network, the duration of the relationship, and the frequency of contact between the subject and the network members; and (3) Total Loss is a sum representing the absence or presence of recent loss, the number of persons lost, and the total amount of support lost in the recent past. For the purpose of this study, these three variables were utilized as total scores because of the small sample size.

Psychometric properties of the NSSQ were reported by Norbeck, Lindsey and Carrieri (1981, 1983). Reliabilities were assessed on two intervals. Phase I test-retest Pearson correlation coefficients were calculated on a sample of graduate nursing student subjects ($N=67$) retested at a one week interval. Pearson correlation coefficients ranged from .85 to .92. The Phase II test-retest correlation coefficients were calculated on a sample of 44 of the original graduate nursing student subjects tested in Phase I. Pearson correlation coefficients at seven months ranged from .58 for the subscale called aid to a value of .78 for subscales of affect and affirmation, indicating moderate stability over this long interval, but consistent with changes that would be expected from those that had occurred in the social networks of the graduate nurses.

Internal consistency was evaluated in Phase I through correlation coefficients. The high level of internal consistency among the affect, affirmation and aid items .72 to .98 ($p<.0001$), among the 3 network property items .88 to .96 and among the three loss items .54 to .68 allowed the items to be collapsed into three variables to be used in subsequent analyses.

Content validity for the NSSQ as a measure of perceived support revealed a high degree of congruence between the instrument's items and Kahn's (1979) conceptualization of social support. Each item in the NSSQ directly relates to the conceptual basis of the instrument. Further, the concurrent approach to validity was tested by comparing the NSSQ with two other social support instruments: the NSSQ and the Social Support Questionnaire (Schaefer, Coyne, & Lazarus, 1981) with the Personal Resource Questionnaire (PRQ) (Brandt & Weinert, 1981). Correlations between NSSQ and these two instruments indicated a moderate level ($r=.28$ to $.51$) of concurrent validity.

Somatic Health Questionnaire

Health was measured by a self-report on somatic health status, an eleven item scale (Health Questionnaire (HQ)) used in Johnson's (1987) study of elderly persons (Appendix I). Items assess an overview of perceived health and symptoms that may indicate impairment in functioning in daily activities. Psychometric data concerning reliability and validity are not available. This adapted questionnaire is presently being used in a study by Johnson with reliability and validity pending.

The Bradburn Morale Scale

The Bradburn Morale Scale (BMS) is a ten item self-report instrument which measured a sense of psychological well-being (Bradburn, 1969) on a four point Likert scale (Appendix J). Bradburn proposed that psychological well-being is comprised of two separate components: positive affect and negative affect. This scale rates positive and negative affective evaluations of one's own internal experiences that

have occurred in the recent past. The instrument was initially used in a pilot study of behavior related to emotional well-being (Bradburn & Caplovitz, 1965) and further developed in a larger study by Bradburn (1969). Bradburn proposed that psychological well-being is a global judgment people make by comparing their negative affect with their positive affect.

The BMS contains three indices of psychological well-being: (1) The Positive Affect Scale (PAS) has five items focusing on pleasurable experiences in the recent past; (2) The Negative Affect Scale (NAS) has five items focusing on unpleasurable experiences in the recent past; and (3) The Affect Balance Scale (ABS) is the combined measure comparing negative affect with positive affect. The ABS is considered the best indicator of an individual's current level of psychological well-being; however, the PAS and NAS scales provide important information about the feeling tone of the individual's recent experiences.

Test-retest reliability of the BMS yielded values for the ten items ranging from .80 to .97, while the three scales ranged from .76 on the ABS to .83 on the PAS (Bradburn, 1969).

The items of the BMS represent a wide range of pleasurable and unpleasurable experiences likely to be experienced in varying populations using this scale. Cluster analysis yielded convergent and discriminant validity of the test items. Positive items were moderately intercorrelated (.50), negative items were moderately intercorrelated (.54), and low associations (.02-.09) between items in the two clusters were found, supporting that the positive and negative affect clusters

were virtually uncorrelated with each other and thus independent subscales (Bradburn & Caplovitz, 1965).

Factor analysis on the BMS using a normal varimax rotation correlation matrix resulted in two factors with eigen values greater than 1.0. The first factor loaded on items reflecting positive affect; the second factor loaded on items negative affect (Bradburn & Caplovitz, 1965). Bradburn (1969) found the Affect Balance Scale to be a consistent predictor of self-reports of happiness. Data from this questionnaire are summarized in a single summary score derived from the sum of negative affect items subtracted from the sum of positive items, yielding the global score of psychological well-being (ABS).

Data Collection Procedure

Consideration of subjects' anonymity and confidentiality were incorporated in the design of these procedures. Before beginning the project, approval was obtained from the University of California, San Francisco, Committee on Human Research. Since licensed residential care operators are individuals whose names are in the public domain, no further agency review processes were necessary for additional human subjects approval. Each potential subject who agreed to participate, read and signed the "Consent to be a Research Subject" form (Appendix K).

Instruments were pre-tested using a sample of retired residential care operators ($n=5$) and mental health professionals ($n=5$) who work with residential care operators. The purpose of this pretesting was to examine the appropriateness of the content of the items and to determine

the amount of time required by the interview schedule. Based on results of this pre-testing, the interview was refined and revised.

Next, key community agency clinicians who work with residential care operators were contacted to screen the names of potential subjects according to the selection criteria of this study. Using the Directory of Community Care Licensing and the inclusion criteria for this study, all operators in facilities categorized as adult residential were reviewed with these agency clinicians for appropriateness of potential subjects for the study.

The investigator then contacted agency staff who work with residential care operators, usually at a staff meeting. The purpose was to introduce the investigator and briefly explain the overall goals for this dissertation research. These introductions served to inform key agency personnel, who might be asked about the study by potential subjects and to verify that the investigator was a doctoral candidate in nursing at UCSF. Staff were requested to refer potential subjects back to the investigator if they had further questions.

The introduction letter was sent to all potential subjects with a follow-up telephone call in one week. If the residential care operators agreed to participate, they were asked the optimal time and place to meet to conduct the interview. The subjects who agreed to participate in this study were told that the investigator would call again the day before the scheduled appointment to reconfirm the time and place. All interviews were conducted from March, 1990 to September, 1990 by this investigator as the only interviewer. Although offices were provided by

the different agencies, most operators ($n=39$) preferred to be interviewed in their homes.

All potential subjects were initially sent the introduction letter. It is interesting to note that some of the interviewed subjects recommended other operators that they thought would be appropriate participants in this study. The investigator asked these subjects for their permission to use their names when calling these other potential subjects to whom a letter had also sent. If permission was granted, a phone call was made to those operators.

At the agreed upon appointment time, subjects were again told the purpose of the study and asked if they had any questions about the study. Informed consent was obtained, and no subject refused the request to audiotape. During the interview, all questions were presented to each subject in exactly the same order and wording. Questionnaire responses were directly recorded on the instruments by the researcher or subject. On the average, the interview was completed in one and one-half hours. At the completion of the interview, each subject was given twenty dollars in cash to cover any expenses incurred by participating in the study (i.e., transportation, work time, etc.). Each subject was reminded to call the investigator at the University of California, San Francisco if they should have any concerns or questions about this study.

Data Analysis

Qualitative and quantitative data were prepared and then analyzed. First, all data were subjected to appropriate reliability checks then

analytic procedures were applied to the data to answer the research questions.

Reliability of the Data

Qualitative and quantitative data were examined for accuracy and reliability prior to their use in subsequent analyses to answer the research questions.

Qualitative Data

Initially, transcriptions of the taped interview data were examined for accuracy. The audiotaped interviews were transcribed verbatim on a word processing software program. The typed transcriptions were checked with the audiotape by another rater to establish accuracy of the content. Next, the interviews were converted and transported into a computer software program, Ethnograph (Seidel & Clark, 1984; Seidel, Kjolseth, & Seymour, 1988). After the interviews were in the Ethnograph program, the lines of the data were numbered in preparation for coding.

Codes determine the organization and retrieval of the data for analysis, thus they have to be precise and their meanings shared among analysts. The content analysis began with the coding for pre-existing categories of stressors, coping, and social support. Then codes for role dimensions were generated from content analysis of the data. These code definitions were given to each rater. Next, this investigator and two other persons independently coded the same interviews with the category codes. These coders were familiar with the theoretical and conceptual issues underlying the codes. In the final step, all raters

discussed the application of codes to all data segments to reach consensus on the definitions. When there were disagreements, definitions were expanded or amended or new codes were generated which were better grounded empirically to fit the phenomenon. These codes were created independently and then validated in group discussions with the other raters.

Multiple-coding was used not only to increase definitional clarity but also as a reliability check. All interviews were independently coded by three raters. Interrater agreement was calculated for the code categories of role dimensions, stressors, coping, and social support of the remaining 35 interviews. Between-rater agreements were greater than the acceptable standard of 80 percent. Interrater reliabilities for stressor codes were 96%, 94%, and 90%. Interrater agreement for coping codes was 92%, 91%, and 89%. Social support interrater agreement was 90%, 88%, and 86%.

Quantitative Data

Questionnaire data were entered on Crunch statistical package software program (Crunch, 1987). Accuracy of the raw quantitative data entered into the computer data file was assessed by examining the frequencies of each item of each questionnaire to search for values that exceeded the possible limits. Reliability coefficients were calculated to ascertain the internal consistency for each of the three questionnaires. The Norbeck Social Support Questionnaire which does not lend itself to examination of internal consistency using the traditional reliability assessment, therefore alpha coefficients were not calculated.

Internal consistency coefficients were calculated for the Caregiver Stress Questionnaire, The Somatic Health Questionnaire, and The Bradburn Morale Scale. The resulting Cronbach's alphas for these three questionnaires in this sample are reported in Table 3.3.

The Caregiver Stress Questionnaire, which was developed in a previous family caregiver study (Norbeck, Chafetz, Weiss, & Wilson, 1985) and adapted for this study, had reliability coefficients that were sufficiently high. The version used in this study originally had 22 items. To raise the reliability of the total and subscales, 1 item was dropped (e.g., reward). This item was worded to elicit qualitative information, not a measure of a specific stressor concept. The resulting 19 items were conceptually grouped into three subscales: Client, Environmental, and Personal. The items that comprise each subscale and their Cronbach's alphas are in Table 3.4.

The reliability coefficients for the two other scales, the Somatic Health Questionnaire and the Bradburn Morale Scale, were below the acceptable standard of .80 reliability set by Nunnally (1978). Thus, in consultation with a statistician, the decision was made to drop these scales from the quantitative analyses. Factors other than measurement error may have contributed to these low alpha coefficients for these two instruments. The Bradburn Morale Scale demonstrated high internal reliabilities in a national probability sample who spoke English as their first language. However, in this sample, for which some subjects English was not their native language, the Bradburn Morale Scale did not perform the same as in previously reported samples. Three items on the Bradburn Morale Scale are culturally-bound, idiomatic expressions

Table 3.3

Study Specific Instrument Analysis Including Reliability Coefficients

Study Concept	Instrument	Number of Items	Reliability Coefficient ^a	N
Caregiver Stress	Caregiver Stress Questionnaire: Total	19	.90	40
	<u>Subscales</u>			
	Client	10	.83	40
	Personal	3	.82	40
	Environmental	6	.76	40
Somatic Health	Health Questionnaire	10	.64	40
Psychological Well-being	Bradburn Morale Scale: Total	10	.46	40
	<u>Subscales</u>			
	Positive Affect Scale	5	.47	40
	Negative Affect Scale	5	.54	40

^a Reliability coefficients were calculated using Cronbach's alphas.

Table 3.4

Caregiver Stress Questionnaire Variables Used to Construct
Subscales

Subscale	Individual Items	Reliability Coefficient
Client	Distressing behavior Communication problems Physical complaints Arguments between residents Medication monitoring Lack of motivation Need constant supervision Hygiene problems Activity monitoring Lack of information	.83
Personal	Interference with own family responsibilities Lack of respite Lack of relaxation	.82
Environmental	Financial problems Licensing problems Conflicting directives Media misrepresentation Residents' family problems Problems with professionals Stigma living with mentally ill persons Problems with neighbors	.76

(e.g., "feel on the top of the world") that may not convey the concept intended by the authors of the original instrument to this study's subjects.

Addressing the Research Questions

The research questions guided the choice of data analysis procedures. Content analysis or descriptive statistics or both were used to answer the research questions. The strategies used for analyzing each research question will be described briefly.

The first research question asked about the demographic characteristics of the residential care homes and the operators. Using the Demographic Questionnaire and Description of the Residential Setting, data were collected in the interview and field notes.

The second question asked about how residential care operators perceive their roles and their perspectives about their work. For this question, the theoretical framework of Litwak (1977; 1985) as discussed in Chapter 2 was utilized to generate codes. According to Litwak, primary groups, especially the nuclear family, are differentiated from formal organizations (e.g., professionals and businesses) in their characteristics and tasks. Using this model by Litwak, the family-like dimension was identified by the following coding scheme: affective aspect of their interpersonal relationships with clients, continual proximity, relative small size (e.g., home-like), actions motivated by internalized altruistic feelings, and commitment to the client. Further, according to Litwak (1977; 1985), day-to-day domestic tasks such as housekeeping, cooking, washing clothing, and personal hygiene

are mostly provided by persons living in the same household, such as families or as in this study, residential care operators. In contrast to primary groups, formal organizations provide professional and business dimensions for persons in usually non-kin, larger institutionalized settings (e.g., large nursing homes and hospitals). For coding purposes professional-like characteristics include: comparatively less intense interpersonal relationships, involvement in specialized instrumental tasks for clients such as treatment and psychosocial rehabilitation. The business dimension, as another function of formal organizations, is characterized by residential care operators' actions toward maintenance of the physical environment and operation of the home (e.g., licensing, repairs) with the major incentive of economic reward.

The answers for the third through sixth research questions were derived from content analysis using the coding schemes for stressors, coping strategies, and social support. Stressors were coded using the key words from each of the individual items on the Caregiver Stress Questionnaire. Coping strategies were coded using the factors defined in the manual for the Ways of Coping Questionnaire (Folkman & Lazarus, 1988) and are listed on Table 3.5. The social support categories used were adapted from Norbeck, Chafetz, Wilson, and Weiss (1991) and are listed in Table 3.6. These codes were described, frequencies within each resulting category were counted and calculated into percentages. These frequencies were presented in tables to provide a graphic representation of this study's subject responses.

Descriptive statistics were used to summarize the data obtained in the seventh research question: What specific factors are associated with social support, such as personal and demographic characteristics of residential care operators and facility characteristics? First, the data derived from the Norbeck Social Support Questionnaire were compared with a normative sample of employed adults (Norbeck, Lindsey, & Carrieri, 1983; 1984). Next, continuous variables such as age, years of schooling, number of residents, number of family members were correlated and categorical variables such as gender, home ownership, marital status, ethnicity, economic level were analyzed using t-tests or analysis of variance.

The eighth research question asked: What are the relationships among stressors, social support, somatic health, and psychological well-being? Correlational analysis were used for exploring of whether or not relationships existed among selected variables. Although associations observed in this sample could generate tentative hypotheses for testing in future studies no attempt was made to draw conclusions about causal inferences.

Summary

A descriptive design was used in this study of 40 residential care operators. This convenience sample represented residential care facilities in Northern California. Data were collected by face-to-face structured interviews and three questionnaires. Interviews were completed by all who agreed to participate in the study, with the

Table 3.5

Coping Strategy Categories and Definitions

Coping Strategies	Definitions
Confrontive Coping	Describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking.
Distancing	Describes cognitive efforts to detach oneself and to minimize the significance of the situation.
Self-Controlling	Describes efforts to regulate one's feelings and actions.
Seeking Social Support	Describes efforts to seek informational support, tangible support, and emotional support.
Accepting Responsibility	Acknowledges one's own role in the problem with a concomitant theme of trying to put things right.
Escape-Avoidance	Describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, which suggest detachment.
Planful Problem-Solving	Describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem.
Positive Reappraisal	Describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension.

Folkman, S. & Lazarus, R. (1988). Manual for the ways of coping questionnaire.

Table 3.6

Support Categories and Definitions

Support Categories	Definitions
<u>Emotional support categories:</u>	
Acceptance	Absence of stigmatization; acceptance of the caregiver despite being related to a mentally ill patient.
Commitment	Demonstrating to the caregiver a commitment to the well-being of the patient, or sharing the burden of caregiving if only through being in contact with the caregiver.
Social involvement	Social contacts and companionship for the caregiver.
Affective	Showing love and caring for the caregiver, including concern for his or her well-being (with qualities of sympathy, compassion, and occasionally true empathy)
Mutuality	Reciprocity in supportive exchanges.
<u>Feedback support categories:</u>	
Affirmation	Validation of the actions, feelings, and decisions associated with the caregiving role.
Listening	Active listening by the support person, provision of a sounding board, and allowing for unburdening by the caregiver.
Talking	The opportunity to talk with another person (without the quality of active listening, emotional presence, or the feeling of unburdening).

Table 3.6 (continued)

Support Categories and Definitions

Support Categories	Definitions
<u>Informational or cognitive support categories:</u>	
Illness information	Information about the patient's illness, care, or supervision.
Behavior management	Information about behavior management strategies.
Coping	Advice about personal coping strategies for the caregiver.
Decision	Help in the decision making process around caregiving issues and includes offering solutions.
Perspective	Supportive interactions which gave the caregiver a new perspective about caregiving or about the caregiving situation.
<u>Instrumental support categories:</u>	
Resources	Help in locating resources, negotiating systems, or advocating for needs.
Respite	Provision of time-off for the caregiver and support for meeting the caregiver's own needs.
Care help	Provision of help with the actual tasks of caregiving, including physical care assistance and monitoring activities (watching the behavior of the patient and setting limits)
Back up	Help is available when needed, including financial assistance.
Household	Help with such home activities as repairs, grocery shopping, or housecleaning.

Norbeck, J., Chafetz, L., Skodol-Wilson, H., & Weiss, S. (1991).

exception of one subject who refused to complete the Norbeck Social Support Questionnaire.

Qualitative and quantitative data were reviewed for reliability. Double-coding of the interviews yielded verification of pre-existing codes and development of new codes. Interrater reliabilities of the codes resulted in intercoder agreement ranging from 89% to 96% for all code categories. The tests for instrument internal consistency resulted in the exclusion of the Somatic Health Questionnaire and the Bradburn Morale Scale in subsequent statistical analyses.

CHAPTER IV

RESULTS

The findings of this study are organized in this chapter by each research question. The analyses of the data identified: (1) the demographic characteristics of residential care facilities and residential care operators; (2) the beliefs and role dimensions of residential care operators; (3) major caregiver stressors and situation-specific coping, and social support; (4) support needs; and (5) correlates of social support, caregiver stress, and well-being.

1. What are the demographic characteristics of this sample: the characteristics of the homes and the personal characteristics of the residential care operators?

Demographic Profile

Characteristics of Residential Care Facilities

Neighborhood Context

The residential care homes varied in specific neighborhood characteristics: the neighborhood type, housing characteristics, the dominant social class, and racial composition. These characteristics are summarized in Table 4.1.

The majority of homes (80%) were located in suburban neighborhoods. The remaining homes were in downtown areas near businesses and universities. About half of the homes were situated near busy streets or major freeways. An operator of a small, suburban home said: "It is important to be near public transportation so that they can

Table 4.1

Neighborhood Characteristics of Residential Care Facilities

Neighborhood Type	Percent of Facilities (N=40)
<u>Neighborhood Context</u>	
Suburban	80.0
Downtown	20.0
<u>Home Characteristics</u>	
Single-Family Home	77.5
Duplex or Apartment	12.5
Large, Multiple Room Home	10.0
<u>Racial Composition of Neighborhood</u>	
Primarily Asian	5.0
Primarily Black	30.0
Primarily Caucasian	22.5
Mixed Ethnicity	42.5

get out and go places." When asked if she had problems with her neighbors, another operator of a larger home said, "The people in the apartment next door can make a lot of noise sometimes but they'll turn the music down if we ask them to".

The neighborhoods were composed of diverse ethnic groups. The majority (42.5%) of the homes were located in ethnically mixed neighborhoods. A cluster of homes (30%) in this sample were located in a primarily Black American neighborhood. Under one-quarter of the neighborhoods were comprised of Caucasians and only five percent were primarily Asian.

Most of the residential care homes (77.5%) were single-family homes. The modal home (70%) had beds for 6 clients with a range of 3 to 48 beds (Table 4.2). One residential care home was a four-bedroom apartment manager's unit which was attached to a larger complex that provided independent living units for other clients. Another larger home in a suburban area had a newly remodelled multiplex addition attached to the home with a large television room, a dining room, and client bedrooms.

A few older facilities in a downtown area were in old Victorian-style homes that were formerly women college dormitories that had been converted into residential care facilities. Although some neighborhoods appeared to be located in middle class neighborhoods, the majority were in either prosperous industrial areas or more impoverished areas. In what appeared to be working class neighborhoods, the adjacent homes had recreational vehicles or boats parked in the front yards and various service trucks (e.g., tow-trucks) parked on the driveways. Some

Table 4.2

Home Size of Residential Care Facilities

Number of Residents in Home	Mean	Median	Standard Deviation	Range	Frequency Number	Percent
<u>Number of Residents</u>	10.625	6	11.65	3-48		
0-6					28	70.00
7-12					4	10.00
11-16					3	7.50
17-36					1	2.50
37-48					4	10.00

residential care homes in high crime areas had chain-linked fences with locked gates, some neighborhood homes had wrought iron window and door guards.

Home Characteristics

The facilities offered different physical and social characteristics. One larger facility was newly painted, each room had its own bathroom, the living room had a large television and videoplayer, comfortable couches, and chairs. Outside this home there was a large backyard with spacious patio areas with picnic tables and an arbor of wisteria covering the patio. In another larger suburban home, the interior appeared like an inexpensive motel with commercial grade rugs and indestructible furniture and lamps. The dining room table was set for lunch at 10:00 a.m. in the morning. Out on the patio there was an old but fully functioning coffee vending machine for residents who wanted to buy coffee between meals. An efficiently run business operation was the orientation of this operator. Despite this stark physical environment, however, this operator had some of the most difficult (e.g., with dual diagnoses) younger male clients and appeared to interact with genuine interest in his clients.

The social environments were somewhat determined by the internal physical structure. Similar to the operator with the coffee vending machine, another operator had a locked door on the kitchen entry. Although there was an open counter between the kitchen and dining area, the kitchen itself was off-limits to clients. However, in another home, the large kitchen had a huge table that was the center for social

gatherings in the home. The operator considered the kitchen to be the place where clients could easily contact her.

Another aspect of the social environment were home rules. All residential care operators described strict enforcement of smoking safety rules mandated by state licensing (e.g., no cigarette smoking in resident bedrooms). Alcohol and street drugs were constant problems and operators took various stances. On one end of the continuum, some operators said they would evict anyone who violated the "no drug" rule. At the other end, another operator who "specialized" in young, chronic clients drew the line at violence due to alcohol or drugs:

We are targeting dual diagnoses people. Some are actively involved in crack or marijuana. All of these drugs make them go crazy. This is a difficult situation to deal with. We believe in the Alcoholic Anonymous approach to treatment. So coming home drunk is not a big problem if it's not a consistent pattern and if they don't get violent. But if they act out violently, then we ask them to leave.

The degree of structure and control of scheduling also varied with the style of the operator and the size of the home. For example, serving meals at scheduled times was described as important for about a third of the operators. The larger the home, the more fixed was the meal time schedule. For most operators curfews had a monitoring function, to make sure all clients were accounted for at the end of each day.

Characteristics of Residential Care Operators

Demographic characteristics of residential care operators in this study are summarized in Table 4.3. The subjects ranged in age from 29 to 77 years with an average age of 51.9 years ($SD=12.4$). Women comprised 77.5% of the sample. Sixty percent were married, and had one

Table 4.3

Demographic Characteristics of Residential Care Operators (N=40)

Characteristics:	Mean	Standard Deviation	Range	Frequency Number	Percent
<u>Age</u>	51.88	12.40	29-77	40	
<u>Gender</u>					
Female				31	77.50
Male				9	22.50
<u>Ethnicity</u>					
Asian				19	47.50
Black				13	32.50
Caucasian				6	15.00
Other				2	5.00
<u>Marital Status</u>					
Married				24	60.00
Divorced/ Separated				6	15.00
Widowed				6	15.00
Never Married				4	10.00
<u>Number of Children</u>	0.925	1.02	0-3		
0				18	45.00
1				11	27.50
2				7	17.50
3				4	10.00
<u>Educational Background</u> (Years)	13.475	2.67	7-18		
0-11				8	20.00
12				5	12.50
13-16				25	62.50
More than 16				2	5.00
<u>Tenure</u> (Years in Residential Care Home)	10.70	8.11	0.3-29		
<u>Relatives Who Work in Home</u>	0.76	1.52	0-8		
<u>Staff: (Number of Paid Staff Who Work in Home)</u>	1.44	3.27	0-15		

(cont.)

Table 4.3 (cont.)

Demographic Characteristics of Residential Care Operators (N=40)

Characteristics:	Mean	Standard Deviation	Range	Frequency Number	Percent
<u>Facility Owner</u>					
Yes				27	67.50
No				13	32.50
<u>Number of Hours Worked per Week</u>					
	139.05	46.82	30-168		
<u>Economic Resources</u>					
Income Not Enough				4	10.00
Income Barely Enough				14	35.00
Income Adequate, No Frills				19	47.50
Income Adequate, Some Frills				3	7.50
Income More than Adequate				0	0.0
<u>Member of Association for Facility Operators</u>					
Yes				31	77.50
No				9	22.50
<u>Participant in Supplemental Services Program</u>					
Yes				22	55.00
No				18	45.00

child living in the home at the time of this interview. Sixty-seven percent reported attending school from 1 to 4 years after graduating from high school.

In this sample, the residential care operators had an average of 10.7 years ($SD=8.11$) experience in residential care. These participants worked 139.05 hours per week ($SD=46.82$). Hours worked was interpreted by subjects to mean they had to be present and available to clients on a 24 hour, 7 days per week schedule, thus the high number of hours reported. Residential care operators reported an average of 1.44 ($SD=3.7$) paid staff who helped them, and on the average one relative worked in the home.

A majority of residential care operators (67.5%) owned or were buying the home. Socioeconomic status was rated on an economic scale developed by Norbeck, et al. (1985). This scale is a 5-point Likert scale that asked subjects to give a self-appraised income ranging from "not enough" to "more than adequate". The modal subject rated income from the business as being adequate but allowing no extra frills.

Subjects reported participating in associations for residential care facility operators at the local and state level. Seventy-seven percent were members of a peer association. Over one-half of the subjects participated in county mental health programs such as the supplemental services program which provides additional funds and mental health consultation to residential care operators for caring for the more difficult patients placed in their homes.

Participants were of diverse backgrounds including: Asians (47.5%) mostly new immigrants from the Philippines (37.5%) and other Pacific

Islands (2.5%); Blacks (32.5%); Caucasians (15%); and Hispanic or mixed ethnicity (5%). The composition of this sample reflects the ethnic diversity in California but is skewed toward greater representation of ethnic minorities. For example, in 1985, proportions of ethnic groups in the San Francisco-Oakland-San Jose area of California were as follows: Asian including Pacific Islanders, American Indians, Eskimos, and Aleuts (12.8%); Black (15.4%); and Hispanic (13.2%) persons (Word, 1985).

To examine the representativeness of this sample, it is helpful to compare this sample's demographic characteristics to subjects in two statewide studies in Table 4.4. These are Segal and Aviram's (1978) state-wide study of sheltered care facility operators, of which the majority of subjects were residential care operators, and Segal, Hazan, and Kotler's (1990) subsequent 12 year follow-up of their original state-wide study. This sample deviates from the two demographic profiles of the larger, statewide studies in several areas due to the sampling process. This sample shows more ethnic diversity, smaller number of beds (e.g., a result of purposeful sampling), and more subjects who were members of associations for facility operators. However, subjects' characteristics are comparable across the three studies on age, gender, and educational background.

2. How do residential care operators perceive their role and what are their perspectives on their work?

Table 4.4

Comparison of Residential Care Operator Characteristics from Three Studies

Characteristics	Study Number ^a		
	1	2	3
<u>Age</u> (over 50 years old)	65	--	57.5
<u>Ethnicity</u>			
Asian	0	19	47.5
Black	41	10	32.5
Caucasian	52	57	15.0
Other	7	14	5.0
<u>Gender</u>			
Female	80	63	77.5
Male	20	37	22.5
<u>Education</u> (Years)			
0 to 11	40	7	20.0
12	20	13	12.5
13 to 16	33	56	62.5
More than 16	7	24	5.0
<u>Manages Large Facility</u> (more than six beds)	64	91	30.0
<u>Owns Facility</u>	84	41	67.5
<u>Member of Local Association</u> <u>for Facility Operators</u>	30	20	77.5
<u>Participates in State</u> <u>Association for Facility Operators</u>	24	54	55.0

Note. The numbers represent percentages.

^a Study numbers include: 1 = Segal & Aviram, 1978 ($\bar{n}$ =55); 2 = Segal, Hazan, & Kotler, 1990 ($\bar{n}$ =69); 3 = Barnes, 1991 ($\bar{n}$ =40).

Beliefs and Role Dimensions

Research question 2 asks, "What are residential care operators' perspectives on their work and how do they perceive their role?" The first section focuses on their beliefs about psychiatric disorders and the second section focuses on their role dimensions with regard to family, professional, and business.

Beliefs

Residential care operators' beliefs or motivations about psychiatric disorders emerged spontaneously throughout the interviews. Their beliefs are fundamental to how they define and interpret their role: ideas about service, illness etiology, and treatment.

Service

The implied reason for choosing this work, expressed by operators, was the desire to provide a needed service to mentally ill persons. They spoke of the importance of recognizing the needs of the mentally ill to have a home, to provide a protective shelter:

They are out of society already. And I care because their families have already deserted them. They would be out on the streets if you don't give them a home. I'm in this because it can help the people. There are lots of people that are homeless

Other operators spoke of social policy ignoring the needs of the mentally ill. A sense of purpose was derived from providing a home for disenfranchised mentally ill persons.

This is the silent population that most people would like to forget. They just would as soon not even acknowledge their presence.

and

The system moves so slowly and not in the direction to benefit mentally ill persons. The homeless get more publicity these days but people forget the mentally ill. It's as if they don't exist.

A prominent belief expressed by residential care operators was that home care is better than institutional care. They asserted a commitment to provide community-based care for clients.

Residential care needs to continue, we've noticed the people who have been institutionalized find it very hard to get back into the community and the longer they've been institutionalized, the harder it is. And we've seen a lot of clients who were institutionalized who should have never been.

Another operator who had worked in a state hospital until deinstitutionalization, firmly believed in the social integration of chronically ill persons into the community. He expressed his belief that smaller homes provide an environment for "normalization", or the opportunity for an individual to establish or maintain personal and social behaviors which are as culturally normative as possible:

The chance for people to come back to "normalization" in their home. If I am going to be a normal person, I am going to live in a normal home. And I cannot live in an institutional environment.

Etiology and Treatment Ideologies

Beliefs about illness and treatment were expressed throughout the interviews. The majority of residential care operators mentioned that severe psychiatric illnesses have a biological basis. It is interesting to note that although no questions were asked directly about their beliefs regarding etiology, this belief in a biological etiology was consistently expressed. Consistent with a biological model of mental illness, medications were identified as an important part of treatment. Thus, refusal of medications might be an early indicator of relapse or might contribute to psychotic symptoms:

I worry about them when they don't take their medications and then they might start acting up and getting sick again.

Also, the identification of symptoms and early intervention was a major theme. Operators, like families, noticed the early changes in behavior that were often idiosyncratic and might indicate an individual may relapse. For example, a change in a client's sleeping or activity pattern may indicate a relapse.

If they don't sleep at night, that's a sign it's time for them to go back (to the hospital). If they are up all night, and it's not permitted here and they know it, they stay in bed and try to control it and stay quiet or they know they are going to go back to the hospital. And as I said, we know that they may be getting sick again.

In a similar sense, an operator saw an indication of relapse when a client begins to misunderstand or misinterpret environmental stimuli:

It is because this client gets very confused, and sometimes he hears voices and he thinks another client is saying bad things about him, then he gets upset and threatens this other client.

In another situation, one operator interpreted clients' noncompliance with house rules as not intentional but as a sign of relapse.

It's not that they choose to break them or something, but ... like the real blatant rule violations, the flagrant ones, are usually associated with somebody decompensating, so it's dealt with in another way.

Thus beliefs, which are based in experience and understanding of clients, influences how operators interpret behaviors, and thus how they approach caring for clients.

Dimensions of Role Performance

Residential care operators perform a unique combination of diverse tasks which makes their role complex. They live with clients, they provide a family-like environment. Providing care to mentally ill

persons, they need specialized skills such as recognizing psychiatric illness symptoms and monitoring medications. Operating a business, they have financial and home management responsibilities. Interview data were coded according to three caregiving role dimensions: family, professional, and business dimensions. The majority of residential care operators had a blending of these role orientations, so that these dimensions did not provide a simple typology. Rather they demonstrated the diversity to which all of the subjects interpreted different aspects of their work. To better understand the diverse interpretations of their roles, these three dimensions will be discussed.

Family-Like Role Dimension

Comments from the interview data illustrate the family-like role dimensions of these subjects. According to Litwak (1977; 1985), primary groups or families are characterized by affection, nurturance, close day-to-day contact, and commitment to persons in their group. Primary groups are motivated by internalized altruistic feelings. Residential care operators expressed affection and nurturance toward their clients.

Affection. Residential care operators referred to affection and nurturance for clients through providing food. While providing meals is part of their job responsibilities, some operators' inviting clients for meals went beyond the mere provision of food. For example, mealtime invitations, especially for dinner or the holidays, were often extended to clients who had left their home to live in an independent setting (e.g., an apartment).

Former clients come and visit, if they're here for dinner, they can eat. I have a lot of compassion for these folks because a lot of them are in a bad way and so young.

and

One of my residents that left, he has his own apartment now. Two times a month he comes and visits us, he's a nice guy. I let him eat with us. He's doing fine.

Other operators include clients in their day-to-day activities such as family and recreational activities, and expressed pleasure in sharing experiences with them. While it is not the intention of this analysis to assess the operators' motivation for including clients in their activities, there were some practical advantages to this sharing. By integrating residents with family functions, these operators could supervise clients while having the opportunity to get together with their own family members. One subject expressed this clearly:

This job doesn't interfere with my family because they accept them. They come and take them out fishing, camping. So they are used to them and they really like them -- that way we're all just like a family. When they invite me for dinner, they invite them or they come here and have dinner. They know that they are my responsibility and I can't leave them

And yet, the affectional component becomes clear in the considerable enthusiasm of operators for including clients or accompanying clients in recreational activities:

I even bring them on picnics. Yesterday we had a picnic with my family. I took all of my residents... and they went and enjoyed it with my family, and it made them happy. I always bring them when we have family reunions, especially the ones who like to eat.

Operators mentioned planning and including clients in birthday celebrations. Although professionals may acknowledge clients' birthdays and other events, some operators went beyond expressing recognition of the event to actually participating and sharing these events with clients. Also, clients were included in holiday celebrations.

We celebrate the holidays and birthdays here. I try to make their birthdays special. Most of them either don't have or don't want their relatives to come and celebrate their birthdays."

Or as another residential care operator said:

When my children were young (they live outside of the home now), it was fun to put presents for everyone under the tree, so we could open with them on Christmas morning and share because it was fun to make it a family affair.

and

In fact, I invite them (former residents) to come here for Thanksgiving or Christmas. We enjoy it and we can tell it really helps them.

The several operators who had small children in the home described the relationship between clients and their young children as mutually beneficial. Although operators who have young children usually pre-screened potential clients to evaluate whether they liked children or not, excluding those who did not, their clients became involved with these children. One operator said:

My kids are close to our clients. Some of my clients babysit my kids. They play games with them. Sometimes they are even more over-protective toward my kids than I am. And they (clients) give them presents on special occasions.

Other examples of affectional activities included taking clients on short vacations to Reno or Disneyland. Some operators, however, commented that unfortunately vacations with clients were restricted by the lack of adequate transportation to accommodate a large group, clients' lack of spending money, and the high cost of automobile liability insurance coverage.

The importance of the interpersonal relationship with clients, keeping open two-way communication, listening to clients, and communicating to them that they are cared for was another affective component emphasized by these subjects.

But mostly, getting along with them is important, and by sharing your feelings with them, they'll share their problems, then you get to know them better.

and

You listen, *the same thing you offer any family member*, anybody that you want to care for, and you have to know when to say "yes" and when to say "no" and when to say nothing.

In addition to addressing the needs of individuals, harmony among group members in the home was an important consideration:

It's always better if you have people that are compatible in many ways. It doesn't matter whether it's females or males mixed together, whether the age groups or whatever, as long as they happen to be functioning at a reasonable parallel, so that they have common interests. It's the same thing as -- *running a home is like having a marriage*. If you have people that aren't compatible, you are going to have problems.

Operators mention becoming a substitute family for clients. Where clients do not have families, operators try to provide some traditional family functions such as visiting clients in the hospital. One operator offered a particularly striking example of family substitution in organizing and attending a client's funeral as a family member, and mourning the loss of a person.

One of them didn't have anybody to go to the funeral but us, but we went and we got a spray to go on the casket and I had the clothes carefully cleaned and so forth. How I missed him, and I just was in tears. (The family didn't show up?) As far as I know, he didn't have any. A lot of them don't.

Knowing the importance of the functions that clients' families can potentially provide, residential care operators encourage them to maintain family ties, when they perceive these relationships as potentially supportive. However, one operator commented on the polarization of family reactions to their mentally ill adult child:

There is really no substitute for family, but there's two ways that parents relate to their children. One is that the parents are so over-involved that they interfere with everything. Then, in the other situation, they refuse to come and visit them at all. Which is just two opposites, and there doesn't seem like anyone is in the middle that knows what to do.

One residential care operator articulates the difference between family and her role with clients. Despite roles as family substitutes, residential care operators appear to differ substantially from families in terms of long-term, intense emotional reactions. Unlike families, residential care operators do not know the client before the illness, and thus do not experience the loss of the function associated with psychiatric disability. Residential care operators made no remarks suggestive of the kind of "empathic grief or loss" that families report in the literature. Instead, residential care operators mostly accept the person's disability, and provide care and support. For example, a residential care operator explains her role is "like a friend helping a friend", whereas taking care of her physically ill, aging mother would be painful, accompanied by loss, helplessness, and sometimes guilt. This operator makes a comparison between residents and her own family:

...so I consider taking care of clients as a friend helping a friend, you know? I have a mother that is ill and she does not live here. I know it would be different and I know there would be pain and hurt there -- to watch her being ill and not being able to change anything as compared to this.

Continuous Proximity

Privacy. The one area of strain expressed by subjects was with the continuous proximity to clients. Many operators were beset with decisions concerning boundaries for their own physical privacy. Several operators mentioned being aware of the degree of involvement with clients. The issue of maintaining physical boundaries is an issue, especially when living with clients twenty-four hours a day. Decisions were made about establishing limits with clients.

Sometimes I go to my bedroom and then they knock on the door. You always have to be available, and you never know if it's crisis or not, so you have to check it out.

Emotional Boundaries. Boundaries also had to do with avoiding emotional over-involvement with clients. One subject said this about the operators' unique position and decision about his relationship to clients:

You don't want to get too attached. Social workers just do their job 5 days a week. If one client leaves, another comes; this is the attitude you have to keep or you'll go crazy all of the time!

As a way of preventing potential hurt, one new operator expressed the need for establishing protective psychological boundaries for herself by not becoming too intensely involved with clients:

You have to carefully monitor changes in each client, monitor their reactions to things. Most importantly, don't get too attached. I've done this and I've learned to back off. I learned the hard way. One of my favorite clients tried to kill himself. I was so devastated and took it personally, how could he do that? I felt so helpless.

Residential care operators, not being family and yet being in close proximity to clients on a twenty-four hour basis, appear to negotiate and make decisions concerning their appropriate physical and psychological space with clients.

Professional Functions of the Role

Professionalism as it relates to involvement in mental health judgments and decisions was another role dimension expressed by operators. Having a contractual agreement encompassed involvement in providing a more specialized service which extends beyond food and shelter. These services include making decisions and judgments about clients' treatment and rehabilitation. The professional function, however, of the residential care operator has the most role ambiguity.

This role is vague and has no formal directives. However, they described similar functions to nurses and other professionals who work in the hospital, constant assessment and monitoring was expressed by operators:

You have to keep abreast of everything going on with your clients. You just kind of observe what they're doing, then you know how to handle them. Because sometimes I have social workers call me to ask me my opinion and mine was better than theirs. This is because I live with these people 24 hours a day.

Operators mentioned the importance of their being prepared to direct clients to get appropriate services and treatment.

We've found that this revolving door thing is constant and I've learned that the second time around may be we can be more influential, like making sure they get the specific outpatient therapy they need.

Other residential care operators saw themselves in the role of supporting clients' treatment and rehabilitation.

Making a major dent in their psychosis is NOT my job. I'm not curing anyone here. Making them comfortable, helping them be (socially) appropriate, and hopefully assisting them to the point where they can move on to a less restrictive home environment are my biggest jobs.

Several operators expressed the importance of continuing education for operators so that they can provide better, informed client care. For example, they expressed the need for education from professionals about clients with dual diagnoses:

We've noticed that more clients were coming to us in the last 10 years with substance abuse problems. Their needs are different so we asked for a class on this.

Additionally, many operators observed the needs of clients' families who were in distress. These operators tried to comfort these families or tried to refer these families to mental health professionals.

Some parents call us with their concerns and there isn't a lot we can do especially when they have big concerns. Then I try to connect them with professionals or direct them toward other resources.

Business Function of the Role

The business role of residential care operators was expressed in terms of managerial and financial aspects of the home including home maintenance, licensing upgrades, insurance payments, and taxes. These essential business tasks were expressed by most operators. They emphasized that operating a business is more than just knowing how to care for clients.

It requires a world of knowledge to be effective. Not only knowledge in dealing with the residents. You have to know your area, you have to know whether it's zoned, you have to know the kind of building you are talking about. You have to check into the buyer department and make sure that things are acceptable for the type of clients you are considering. You have to know the resources. You have to know the economics if you can make it. You have to know that it requires money.

For many residential care operators, continuing in the residential care home business meant efforts to keep the beds full and trying to financially "break even". The greatest strain was in trying to balance business while providing care in a professional manner. One operator summed up this problem:

There isn't that much money in this work, so don't go into it to get rich because you won't. There is a standard that you want to maintain, this means not short-changing the clients.

Many reported not being able to financially break-even, that they were supplementing their income with other jobs. Others planned to get a bigger facility or remodel their home to increase the beds and thus increase their revenue.

That's the only way I can manage. If we didn't have other income, we could not do this. Like CARCH (California Association of Residential Care Homes) put out a flier on the six bed home and they estimated the operation at about \$7,000 a month and the

estimated income is \$4,000 so you are working for nothing and basically working to pay the rent. I happen to live here but if I didn't...

Further, some residential care operators expressed different factors influencing their commitment to stay in business. The benefits of the job included having a good interpersonal and physical working environment. Some emphasized the autonomy of being one's own boss (e.g., taking coffee breaks when you want to, or watching your favorite soap opera) or being able to be in business for oneself, perhaps being able to buy and invest in a home.

But the only reason I stayed was because, as I said, even if I go out to work the income that I'll get from work would just be enough to pay for the rent and utilities, and the benefits that I'm getting from here is that I get to buy a house, it's an investment.

Another advantage was not driving to work in rush-hour traffic, having to buy a working woman's ("dress for success") wardrobe. Another potential benefit of an autonomous job, for some residential care operators, was being at home with their young children.

Conversely, an economic drawback of the job was inadequate compensation in the context of inflation, and thus a few operators expressed the desire to find another job:

With increasing inflation and the lack of compensation, I take it as it is and I figure that when I am no longer able to manage it, I will discontinue the operation.

A few other operators wanted to change their licenses from mentally ill to elderly or developmentally disabled clients since social security benefits are greater and thus their income would thus increase. Some younger operators planned to get degrees in nursing and leave the business to work in hospitals where they would get increased pay for fewer hours worked:

I'll retire and go back to work (as a LVN) if they'll hire me. I want only an 8 hour job! To go back as an LVN, I'll have to go back to school and take a refresher course.

3. What are the major stressors of residential care operators?

Highest Ranked Caregiver Stressors

Table 4.5 shows the rank-ordered caregiver stressors identified by residential care operators. Each subject selected their three most severe stressors after completing the Caregiver Stress Questionnaire portion of the interview. The three problems rated as the highest in severity served as the basis for intensively probing into the specific coping utilized and social supports extended to these subjects. It is important to note that although many problems were universally rated as mild to moderate stressors, they were not necessarily ranked as the most intense stressors. For the purpose of this discussion, the highest ranked stressors have been organized into three overarching categories based on the type of specific stressors. These three categories are: client stressors, personal stressors, and environmental stressors, and are defined as follows: (1) Client stressors include those related to the management of clients' behaviors; (2) Personal stressors include the impact of caregiving on one's personal and family responsibilities; and (3) Environmental stressors include external factors such as dealing with mental health professionals, financial, and licensing regulation issues.

Table 4.5

Highest Ranked Caregiver Stressors

	Rank Order of Total Stressors	No. of Total Stressors (n=119)	% of Total Stressors	No. & % of Subjects ^a	Category ^b
Distressing Client Behaviors	1	36	30.2%	23 (57.5%)	1
Respite (lack of)	2	14	11.7%	13 (32.5%)	2
Financial (problems)	3	10	8.4%	10 (25%)	3
Licensing (problems)	4	8	6.7%	8 (20%)	3
Clients' Families (problems)	5	7	5.9%	7 (17.5%)	3
Hygiene (problems)	6	6	5.0%	6 (15%)	1
Health Professionals (problems)	7	5	4.2%	5 (12.5%)	3
Information (lack of)	7	5	4.2%	5 (12.5%)	3
Staff (lack of)	7	5	4.2%	5 (12.5%)	3
Arguments (between clients)	8	4	3.7%	4 (10%)	1
Media (misrepresentation)	8	4	3.7%	4 (10%)	3
Medications (monitoring)	8	4	3.7%	4 (10%)	1
Communication (problems with clients)	9	3	2.5%	3 (7.5%)	1
Family Responsibilities (interference)	9	3	2.5%	3 (7.5%)	2
Motivation (clients' lack of)	10	2	1.7%	2 (5%)	1
Neighbors (problems)	10	2	1.7%	2 (5%)	3
Clients' Physical (problems)	11	1	.8%	1 (2.5%)	1

Note. A total of 119 stressors were ranked as most stressful, or three for each of the 40 subjects. One subject only ranked two stresses, thus 120-1=119.

^a Some subjects selected more than one stressor in a given category when ranking their three highest stressors.

^b Stressors are classified as: 1=client; 2=personal; 3=environmental.

Stressor Categories

Client Stressors

Distressing Behaviors

Distressing behaviors of clients were ranked as the highest stressor (57.5%) by the residential care operators. Corroborating the results of previous family studies, clients' problem behaviors, and emotional state are ranked as the highest stressor (Chafetz & Barnes, 1989), are the most disturbing (Tessler et al., 1987), and account for the intense burden experienced by families (Thompson & Doll, 1982). This is a significant finding since it is frequently assumed that financial stressors are the greatest stressors for residential care operators (Blaustein & Viek, 1987).

Although suicide was a rare experience, the fear of a potential suicide was frequently mentioned as one of the worse possible client behaviors.

...because you're dealing with life and death type of situations. So we had to constantly check, and I called for help. So I just spent very long evenings thinking about some of these things like suicide.

and

... a client that said he was possessed by demons. This man told me that he was "losing it and I feel that I am going to jump through this window". Well, I watched him, and I even kept him a little longer than I felt that I should have (for safety reasons).

The violent, disruptive client caused enormous stress, especially when there was potential for violence toward other clients or staff. Concern for the safety of others and the dread of ever possible violence was expressed.

The behaviors, the violent, disruptive behavior that could occur anytime, and that's very upsetting because the hostility, verbal abuse, the people in the house could be hurt.

Anticipation of impending client decompensation, with increased agitation and disruption in the home, was another stressor. In addition to clients' acutely psychotic florid symptoms, clients' mood changes or lability caused distress.

My most stressful time is when D. gets high. He's a manic depressive and when he gets high he drives me up the wall. Other than that, the guys are pretty calm and I'm a calm person. But when he's high, he will leave the house at night or he gives away all the clothes, he would give away everything in the house -- his things, my things, anybody else's things.

Related to these changes, the unpredictability of distressing behaviors was mentioned. For example, unpredictable behaviors kept some subjects on edge.

When you get up in the morning, you think this is what I plan to do today, but you never know, your plans may change. This is stressful because one of them (clients) may change suddenly and something bad might happen.

and

Like the way he acts. You never know what to expect. He would be up all night. And in the morning there would be coffee spilled all over, food all over, he raided the refrigerator, and the first thing you have to do is clean up this mess on the floor -- that's stressful.

Associated with violent, impulsive client behaviors is substance abuse, or situations in which clients who take street drugs become uncontrollable. Younger clients with concomitant substance abuse are particularly difficult and require a disproportionate amount of the operator's energy and time. While a single client can cause a considerable disturbance in a home with others, these clients often instigate other clients. Having experienced problems with young clients, several operators mentioned that they preferred having older clients live in their homes:

The younger ones are not just a problem by themselves. They get others involved in drinking or drugs and then you've got major problems. I'm beginning to select older clients.

Client behaviors that seem to be minor nuisances included messiness and hiding food. However, major safety issues were critical when a client might start a fire accidentally. Several operators mentioned the need for constant vigilance when her clients smoke cigarettes in their bedrooms.

It sets me on edge because I never know if they'll smoke and drop their cigarette (and cause a fire). I have to get up often all through the night to check on them.

Unlike families, residential care operators may experience multiple, concurrent client-related stressors. For example, major arguments between two clients that result in threats and potential violence were perceived as frightening. Subjects described how minor arguments might escalate and become difficult to control. Also, multiple client and family crises might co-occur. For example, one subject emphasized her distress when a severe client crisis coincided with an illness in her own family:

When everything happens at once ... The week when my mother had major surgery and a client threatened his father and was hospitalized.

Hygiene

Monitoring and assisting clients with their hygiene was ranked as highest by only 15% of the subjects ($n=6$); yet these activities can be contentious. When clients and residential care operators have different expectations for personal cleanliness, a struggle may result. Common complaints were when clients refused to bathe despite having body odor. Even though they described attempts to persuade clients, operators

mentioned clients' unwillingness to take care of their own self-grooming and hygiene. One operator reports:

It's hard to get them to shave, bathe, or go to the barbershop. I say, "This is not just a reflection on you, but on me too." And I will pay for him to go to the barber, and he won't go (frustrated with this situation).

and

Sometimes, you feel embarrassed that they go outside and look like they never bathe or wash their clothes but a few won't let us even mention "shower" to them.

Monitoring Behavior

Medication issues concerning monitoring client compliance were mentioned by almost all operators, even though only 10% ranked it as one of their three highest stressors. Residential care operators attributed the stress they felt concerning their clients' noncompliance or refusal of medication with the possibility of exacerbation of symptoms and a subsequent psychotic decompensation. One operator expressed her concern with medications, not only as a stress for herself, but for the client.

It's stressful with medications only when they refuse them. Then, you know, a few of them have refused to take them, they would say, "I'm fine now, I don't need them." And they quit taking them, which they have the right to do, and then you see them decompensate.

Lack of Motivation

Client behaviors that were the result of deficit or negative symptoms such as the lack of motivation (5%) were not as salient for residential care operators as compared to family caregivers. Only two subjects ranked clients' lack of motivation among their three highest stressors, and three ranked problems with disturbed communication.

However, lack of motivation, apathy, and inactivity were perceived as part of the clients' illnesses or a side-effect of the psychotropic

medications, and thus was mentioned infrequently as one of the highest three stressors:

Their withdrawal is only a moderate stress because it is part of their illness. We have to find out how much they can do so that we can have realistic expectations.

Communication Problems

Clients' poor concentration and lack of attention, perhaps due to cognitive deficits and attentional processing problems, was mentioned as the most stressful by 7.5% of the subjects. She discussed her distress with regard to a noncommunicative client, even when it seems unintentional:

... They won't communicate when they're in their own world. You stand there, you just talk to them and say it again and again.... The most severe stress is when you have to go over and over about the same things. But acute symptoms, that's a mild stress.

Client Physical Problems

Clients' physical problems were ranked among the highest stressors by only one operator, but other subjects mentioned the responsibility of having to accurately determine whether clients' physical complaints needed medical attention. This was potentially serious for illnesses such as diabetes or cardiac problems. Although this was rarely among the highest ranked stressors, making decisions about when to take a client to see a medical professional was a source of serious concern expressed by some operators ($n=8$).

Personal Stressors

Lack of Respite

Similar to families, the lack of respite from caregiving tasks was a major stressor. Respite has its significance in providing personal

relaxation and socialization outside of the home. Lack of respite (ranked by 32.5% of the subjects) was second to distressing client behaviors by subjects. Many subjects mentioned that they did not have enough time away from the demands of their jobs. The subjects with smaller homes with no staff, mentioned the 24 hour, 7 days a week responsibility interfering with their ability to get a break or away on a vacation. Confinement, not only the lack of relaxation, was mentioned as the major stressor. One subject described not the inability to relax, but the confinement of the work:

... to feel like a prisoner in your own home. It's like you're on duty 24 hours a day. When you want to do something but you can't do this, especially if you're in business by yourself....

Lack of respite due to twenty-four hour responsibility is compounded by intrusions into one's private life. Several subjects mentioned the stress of having to be accessible to clients, and unable to get away.

Even when you go to bed at night, you know that someone might knock and you never know, it could be important.

The responsibility of the job extended beyond the home. Even when an operator could get some staff to get away, they could not go as a family.

It's too hard to leave, you don't know if the person relieving will do the things right. My cousins help us, but only for one day when we go on a trip. When we went to Disneyland, my husband had to stay home. We should go as a family. One of us always has to be here.

Further, plans to get away from the home were often canceled because of a client emergency, resulting in disruption in social engagements.

Also, I cannot socialize like before, I cannot invite friends over. When I make plans to see friends, then some emergency, like one of the clients needs attention for some crisis. They don't

seem to want me to leave, so it's very difficult to get away. So I don't schedule anything anymore.

Interference with Family Responsibilities

Only three of the residential care operators ranked disruption in responsibilities to their own family members as one of their highest stressors. However, the twenty-four hour responsibility caused some family disruption especially with residential care operators who have young children in the home. These subjects expressed difficulty in trying to balance work and family life. For these operators, client problems competed with day-to-day family responsibilities. For example, sometimes family plans to go out or go on vacation had to be canceled because of a client emergency. As one operator describes a vicious circle of caregiving being a top priority and thus she gets no time away, resulting in no time with her family:

And then sometimes I make plans with my family. I say, this day I will spend with my family, but something comes up and I have to cancel these plans.

and

I cannot spend time with my family, can't go out, can't go on vacation. So far we haven't gone on a family vacation. This is the hardest for me.

Environmental Stressors

Financial Problems

Financial concerns were ranked as the highest of the environmental stressors. However, financial problems were ranked highest by only 25% of the subjects. While financial concerns were mentioned consistently in the interviews in terms of residential care not being a profit making business, they did not cite financial stressors as their most intense

stressors. A plausible explanation is that the financial difficulties of the work may be resolved or put into perspective by operators who continue in this business. For example, other factors such as control in being one's own boss or being able to purchase a home may compensate for the lack of adequate financial reimbursement.

Decreasing financial resources for the mentally ill, increasing inflation, high taxes, mortgages, and liability insurance costs have made home operation difficult. One operator expressed the dilemmas of inadequate reimbursement:

I don't mean that money is going to necessarily buy this service, but certainly that's going to have to be there in order to provide it. And unfortunately, it's a very expensive deal.

Another operator mentioned the inequity of high responsibility for clients not balanced with compensation for this work:

I feel that inasmuch as government agencies who take care of the residents on an inpatient basis, inasmuch as their cost is tremendously more than the compensation that's allowed the residential care home, there should be more consideration given to the compensation because the residential care home has basically the same responsibility as the institutional facilities, such as hospitals.

Financial pressures contribute to inability to hire even part-time staff. The operators of smaller homes mentioned not being able to get anyone to help them with their work. Further, financial pressures had an impact on residential care operators' expectations to maintain their desired standards for care in their homes.

It's primarily trying to maintain the kind of operation that one wants, and again it's back to our own expectations, so trying to keep things as professional and as high as one can. To keep a facility looking nice and keep all the equipment running properly, and fix the broken doors, and all of a sudden you've got an inspection coming in for your sprinkler system and you've found that the last time they paved the street they moved your pipes out there and the guy pulls the cover off and found that thing is jarred and you have to get a new unit and it's going to cost you \$400 just for the piece alone.

Licensing

Licensing placed enormous demands on residential care operators. Meeting the demands of what are perceived as constantly changing licensing regulations is a substantial stressor expressed by 27% of the subjects. Describing some of the requirements for maintaining and upgrading the physical environment of the homes as unrealistic and expensive, they state that the priorities set by licensing agencies are expensive and often nonproductive. For example:

Some of their rules, I'm not sure that they serve the clients. Like we have had to put in this huge signalling device; every room has a buzzer that can be pushed in case of an emergency. We put it in 6 years ago and we have yet to find it useful.

Licensing regulations are often perceived as dealing with trivial objections such as getting a citation for not refrigerating jelly or jam or not having a certain amount of frozen vegetables stored in the freezer. One operator expressed her belief that these regulations are not relevant to the quality of care:

Licensing makes a big thing out of things that aren't major. We think citable things are patient abuse, mental cruelty, instead of dirty slacks. Because, as you know, we confront them, we clean their clothes, and when you turn around, they put another pair of dirty slacks on!

Additionally, the amount of requested documentation is perceived as overwhelming in relation to the other demands of the job, which makes compliance extremely difficult.

Now we have to keep records to the point that this has become a full time job.

Clients' Families

Only seven residential care operators (17.5%) cited unrealistic or excessive demands of family members to be a top ranked stressor. Many subjects commented that family members were at two extremes of a

continuum, over-involved or disengaged. Although one subject empathized with these families in that they "are in a totally impossible situation", the over-involved families would place unrealistic demands on the operator concerning their mentally ill relative. One operator commented on this situation:

They put a lot of pressure on the operator. It almost feels like it is your child instead of theirs! Because they feel that I'm paid, you're supposed to work miracles. It's not a vicious thing, it's their guilt and the way they're feeling, and you're supposed to make it all right.

or,

They feel that a lot of the things that they were able to do for their relative, they're still able to do, but the responsibility of medications and all the social things that must be done is now on us. It's kind of a one-sided, they don't want to take on the responsibility at the same time they want the same things that they used to give or they would like to give.

Despite the pressures from some clients' family members, overall operators tried to respond empathetically and realistically to their needs. One operator commented:

You talk with the parents. In my situation, I try to understand what they may be going through. It takes time to deal with the realization of your child's illness. So I deal with situations as they come up.

Health Professionals

Although problems with health professionals were common concerns described by most residential care operators, only five ranked this among their highest stressors. Frequently mentioned difficulties were lack of recognition of operators, one-way communication, conflicting directions, and a lack of continued attention for clients' health care needs. The primary communication problem described was professionals not listening to subjects' observations of clients' behavioral changes. For example:

If they (professionals) only would trust our assessments. We know these persons because we live with them 24 hours a day, 7 days a week. We can see the changes. One problem is that you have to see the relapse coming on. When it becomes apparent, we can no longer reach them; then things get out of hand.

and

... we saw him decompensating and nobody (i.e., professionals) would listen to us, and we knew he wasn't the same, and finally they came in. Yes, he was decompensating and they sent him off to the hospital for ten days; now he's back and stabilized. But, it is stressful because nobody will listen to you -- that's stressful.

and

He (a psychiatrist who was admitting a client) said this as if I were to blame for the situation in front of my client. Very rude. Like I was stupid and knew nothing and he is God and he knew everything and the primary people, the best people, with the best information are the people who are living with somebody 24 hours a day. Most of the psychiatric evaluations are done on the basis of history and you've got to have reliable history. Not just because the client tells you some grandiose story.

The large number of sources and agencies that residential care operators depend upon for information about facility operation or client care could create problems. Interestingly, not even one residential care operator listed conflicting directions from multiple sources as a stressor. When asked if they received conflicting directives, the typical response was, "That's not a problem because the home operation licensing has the final word." Thus, licensing regulation provides structure to what could be a potentially stressful situation.

Lack of Information

The lack of communication from professionals concerning clients constituted a substantial stressor. On the long term, professionals did not always communicate treatment changes to residential care operators. One operator talked about the lack of communication regarding a major medication change for one of her clients.

I had this client, and the doctor was decreasing the client's Prolixin injections and I kept telling the doctor about this client's highs and lows, and he's talking about the FBI. As the client got progressively worse, I had no idea he was being taken off drugs. Five months prior to this, they had begun gradually decreasing his Prolixin dosage -- would they bother to tell me this?

There was also a lack of information about the client who was referred from the mental health system to the residential care operator. Many operators mentioned the lack of important client information, especially about special needs or unusual behaviors.

And people don't realize, we have to live with these people 24 hours a day, just like they were our family and we need to know what they're capable of doing, for our own personal safety.

When essential information was not communicated, operators often discovered client behaviors by default:

Well, it usually doesn't work out after a while and it all comes out once you get them here and you start living with them. You know what the problems are and you haven't been told. But you know this is not something that just started because they got here. So this is how we find out.

Staff

Understaffing or the absence of staff was ranked as the highest stress by five subjects (12.5%). The lack of funding was the major reason that limited the ability to hire staff. Understaffing, which is directly related to lack of respite from caregiving responsibilities was frequently mentioned as a serious problem for operators. Most operators mentioned that it is difficult to find qualified people who were reliable.

I need a more qualified person when I'm not here. This puts a stress on me to be here. You need more than a cook and housekeeper to look after these people.

and

We could improve that if we had more funds to employ people. We could employ somebody that could be more qualified to do the job. More funds for recreation and therapeutic activities.

Media

Media sensationalism and misrepresentation of residential care homes was selected among the highest ranked stressors for a small number of subjects (10%). However, it is important to mention this topic because almost one-third of the operators felt that the television, sensationalizes residential care. They expressed the desire for the media at least to balance the negative cases with the positive aspects of residential care. A major concern is the exploitation of the media of the occasional unlicensed home. One operator expressed her viewpoint on the unlicensed residential care home for elderly clients in Sacramento, California:

It makes all of us look bad because the public remembers the operator, obviously, not the social worker's or state's responsibility, and there was something very strange because the social worker had to know what was going on. Would you continue to place your clients in a facility where they were missing or gone, and continue to send a check to this operator's home when you already have placed someone else in this "missing person's" bed? So it wasn't a licensed residential care home; if it had been, they would have checked her (the operator's) fingerprints and found out that she was a criminal.

Neighbors

Although problems with neighbors have been mentioned in the literature as a potential problem for establishing residential care homes, it was a highest ranked stressor for only two subjects. A few operators reported that some neighbors could be antagonistic, especially about house values.

One neighbor who has interest in house values, he's a real estate man, three blocks away, questions me about why we have residents. I got some support from the city council. We're concerned with people not having enough places to live. These clients are like any other people.

However, for the most part they recognized that poor relationships with neighbors could jeopardize their continuation in business. Thus, operators took measures to control bizarre client behavior so as not to upset neighbors.

Sometimes some of the guys are very bizarre and the neighbors get upset but if they tell me I can take care of these situations. Some of them just don't like it (having a home with mentally ill persons in their neighborhood).

Summary

The cumulative frequencies of the three categories of stressors for the highest ranked stressors are as follows: client-related stressors were 47%; environmental stressors were 39%; and personal stressors were 14%. Distressing client behaviors comprised the majority of client-related stressors. Lack of respite from caregiving responsibilities was the greatest personal stress. Financial problems and concerns and licensing problems were the greatest environmental stressors.

4. What coping strategies do residential care operators use for specific types of stressors?

Coping strategies of residential care operators were elicited through a series of questions about problems ranked as the highest stressor. Following the framework of Lazarus and Folkman's (1984) theory, coping responses were classified as problem-focused or emotion-focused. Problem-focused coping refers to efforts undertaken to manage or alter the source of stress. Emotion-focused coping refers to efforts undertaken to regulate stressful emotions. These two broad

classifications were further divided into specific coping categories (Folkman & Lazarus, 1988). Problem-focused coping strategies include planful problem-solving, confrontive coping, and seeking social support. Emotion-focused coping includes accepting responsibility, distancing, escape-avoidance, positive reappraisal, and self-controlling (see Chapter 2 for definitions).

Some data segments did not fit into these categories, thus a new category emerged named "resignation." This new category, resignation, emerged as a coping strategy that described subjects' cognitive efforts to accept, despite efforts that might be made, action on their part would not change the situation.

An overview of the frequency of each coping strategy mentioned during the interviews is presented in Table 4.6. Problem-focused coping (e.g. planful problem-solving, seeking social support, and confrontive coping) accounted for seventy-seven percent of all coping strategies. In addition, these three highest ranked coping strategies are all problem-focused coping strategies, or directed toward taking action to change the stressful situations. The results of the frequencies of coping strategies mentioned with regard to the specific highest ranked stressors and are displayed in Table 4.7. Some subjects mentioned more than one coping strategy in response to a specific stress, thus a total of 148 coded segments were identified for all 119 of the highest ranked stressors.

Coping Strategies: Category Summaries

Problem-Focused

Similar to mental health professionals, residential care operators utilize problem-focused coping strategies. Active planning and evaluation of solutions to complex problems were used in the majority of stressful situations mentioned in the interviews.

Planful Problem-Solving

Problem-solving was the coping strategy mentioned with the highest frequency (38%) by subjects as how they dealt with all of the highest ranked stressors. Strategy included making plans of action, changing things, drawing on past experiences, and working extra hard to accomplish the goals. Overall, planful problem-solving was mentioned a minimum of one time by subjects for each of the stressors, except for the stressor called media sensationalism. Subjects mentioned a thoughtful approach to defining the problem, reflecting on it, gathering appropriate data, and identifying alternative solutions. The goal was to focus on creating an action plan to solve the problem.

In dealing with distressing client behaviors, planful problem-solving was the second most frequently (37%) mentioned coping strategy. This included actively assessing clients directly:

I try to find out what is bothering them, what is the matter. I try to keep in contact with them. All you can do is talk with them.

In potentially violent situations, intervention is more complex:

When they argue, I talk with them and try to calm them down. Most of the time they will listen to me. Then I ask one of them to leave the room, so I can talk to each one of them separately to find out what happened.

Table 4.6.

Coping Strategies Mentioned for the Highest Ranked Caregiver Stressors

	Rank Order	Number of Coping Strategies	Percent of Coping Strategies
Planful Problem-Solving	1	56	38%
Seeking Social Support	2	36	24%
Confrontive	3	22	15%
Resignation	4	12	8%
Distancing	5	8	6%
Escape-Avoidance	6	7	5%
Self-Controlling	7	3	2%
Accepting Responsibility	8	2	1%
Positive-Reappraisal	8	2	1%
TOTAL		148	100%

Note. The percent of coping strategies is calculated by dividing the number of coping strategies by the total number of coping strategies.

Table 4.7 Coping Strategies for Specific Caregiver Stressors

Caregiver Stress		Coping Strategies								
	Accepting Responsibility	Confrontive	Distancing	Escape-Avoidance	Positive Reappraisal	Planful Problem Solving	Resignation	Seeking Social Support	Self Control-ling	
Distressing Behaviors [42]	1 (1%)	6 (15%)	0	0	0	15 (37%)	1 (1%)	19 (46%)	0	
Respite [21]	1 (4%)	1 (4%)	2 (10%)	4 (20%)	2 (10%)	3 (15%)	2 (10%)	5 (23%)	1 (4%)	
Financial [13]	0	0	2 (15%)	0	0	6 (47%)	3 (23%)	2 (15%)	0	
Licensing [9]	0	1 (11%)	0	1 (11%)	0	7 (78%)	0	0	0	
Clients' Families [9]	0	2 (22%)	0	0	0	5 (56%)	1 (11%)	1 (11%)	0	
Hygiene [8]	0	6 (75%)	0	0	0	2 (25%)	0	0	0	
Health Professionals [6]	0	1 (16%)	1 (16%)	0	0	1 (16%)	2 (36%)	1 (16%)	0	
Staff [6]	0	0	0	0	0	3 (50%)	1 (17%)	2 (33%)	0	
Information -- Lack [7]	0	1 (14%)	1 (14%)	0	0	2 (29%)	2 (29%)	1 (14%)	0	
Arguments (between clients)[5]	0	1 (20%)	0	0	0	4 (80%)	0	0	0	
Media [5]	0	1 (20%)	1 (20%)	1 (20%)	0	0	0	2 (40%)	0	
Medication [5]	0	0	0	0	0	3 (60%)	0	2 (40%)	0	
Family Responsibilities [3]	0	0	0	1 (33%)	0	1 (33%)	0	0	1 (33%)	
Communication [3]	0	1 (33%)	0	0	0	1 (33%)	0	0	1 (33%)	
Motivation [2]	0	1 (50%)	0	0	0	1 (50%)	0	0	0	
Neighbors [2]	0	0	1 (50%)	0	0	1 (50%)	0	0	0	
Physical [2]	0	0	0	0	0	1 (50%)	0	1(50%)	0	
TOTAL: 148	2 (1%)	22 (15%)	8 (6%)	7 (5%)	2 (1%)	56 (38%)	12 (8%)	36(28%)	3 (2%)	

Note. Numbers in parentheses represent the percentage a given coping strategy was mentioned for a given stressor. Percentages rounded off to equal 100% for a specific stressor. Numbers in brackets indicate the total coping strategies mentioned for a specific stressor.

With violent or out of control situations most subjects initially take action and then seek social support. Operators said, "First, I try to deal with the situation by myself, then I try to contain them for their own safety and ours, then I call the doctor."

With another distressing client behavior, noncompliance with taking prescribed medication, operators mentioned a variety of strategies to get clients to take their medications. For example, when other more direct methods were unsuccessful, distraction was a technique used to get clients to take their medications. As one operator said:

I give them their medication and then I ask them about how their day went. I get them to talk and keep them around until I think they swallowed the medication.

In coping with environmental stressors such as problems with clients' families, operators mentioned giving information or advice to these relatives, mostly referring them to mental health professionals or to family support organizations such as the California Alliance for the Mentally Ill. Financial or licensing stressors required a more direct approach to solve the specific situation, whether it be working another job or making changes required by licensing regulations. For intense personal stressors, such as the need for respite or interference with family responsibilities, planful problem-solving was rarely mentioned by operators. Oftentimes a direct approach was not used because the potential for changing these situations was perceived as unlikely by these subjects.

Seeking Social Support

Talking to someone to find out more about the situation, seeking someone who could do something helpful to solve the problem, and asking

someone who is respected for advice are examples of how residential care operators approached stressors. Overall, seeking social support was used as a coping method in 24 percent of the instances in dealing with the highest ranked stressors. Residential care operators appropriately involved others, both professionals and peers, especially when they needed direct help with distressing client behaviors. In fact, seeking social support was the most frequently (46%) utilized coping strategy for client-related stressors. For example, to deal with client emergencies, subjects said, "you try everything and then in the end you call 911 (for help)" or "I call the client's therapist to come and evaluate him."

Many operators described talking with others about difficult problems, seeking advice, information, and consultation. Having professionals listen and intervene in behavior management and treatment was important. With regard to dealing with client-related problems such as client crises, direct assistance from professionals was sought with the highest frequency. Others consulted other operators who would listen, share, understand, and give advice based on having common experiences. More than a few subjects commented that local and statewide associations provided an opportunity to interact with their peers about issues, such as legislation, that influence their business. For dealing with personal stressors, such as lack of respite, operators mentioned asking family members to come and stay with their clients while they went on a break or took a brief vacation. One operator said of her adult daughter, "I ask my daughter to come and stay here while I

go to church, she goes to work Monday through Friday but even a little break helps."

Confrontive Coping

This strategy included directly taking a stand on issues and expressing this to others. Confrontive coping was utilized in 15 percent of the situations with regard to all of the highest ranked stressors. Residential care operators seemed to be skilled and comfortable using this coping style. Expressing feelings such as concern seemed to be a preferred strategy in trying to correct some problems with clients. For example, with clients who need to follow through with their own personal hygiene, such as taking a bath, confrontation was used for 75% of the instances. One operator said, "I keep reminding them that they have to take a bath or shower and change their clothes. If I don't tell them directly nobody else will."

Confrontation made the operators feel successful in taking action to benefit clients or change an unfavorable situation. For example, confrontation was mentioned by one operator to get information from a mental health professional who tended to withhold pertinent information about clients:

So finally I have learned to say, 'this seems to be continuing pattern, we call you and you have not given us important information that was in the record and I need you to tell me or we won't continue to take your clients'.

Emotion-Focused Coping

Emotion-focused coping involves strategies that do not change the situation but cognitively reframe the meaning of a potentially stressful situation. The subjects in this study used these strategies in

situations that did not directly involve clients. These coping strategies were used with persistent, chronic personal and environmental stressors that were not readily amenable to action that might result in change.

Escape-Avoidance

The coping strategy of escape-avoidance was used in only five percent of the instances with regard to the highest ranked stressors. Escape-avoidance included wishful thinking, avoiding others, or trying to make oneself feel better by engaging in behaviors such as eating, drinking, and smoking. A few residential care operators wished the situation were different or became involved in a diversionary activity to get away from the problem. For example, one operator went out into the garden, painted a fence, or reorganized closets. Escape-avoidance is a cognitive strategy that was used primarily to deal with the lack of respite. One operator who rated the need for respite as one of her greatest stressors remarked:

Sometimes I work in my garden and then when I come back its like getting away doesn't matter.

Resignation

Resignation was a coping strategy used in 8 percent of the situations. Resignation was characterized by a sense of powerlessness when all attempts to solve the problem with other strategies had been defeated. Operators oftentimes may have to deal with impossible situations where they have little perceived control, thus it is not surprising that enduring or giving-up was utilized when there seemed to be no other recourse. It is interesting to note that resignation was

mentioned only one time in dealing with distressing client behaviors and not mentioned at all for other client-related behaviors such as hygiene, arguments, medication, or clients' lack of motivation. Rather, resignation was mentioned with regard to health professional related problems and lack of information about clients. About the lack of important information about clients from professionals, one operator remarked:

You don't have any way to deal with it (the lack of client information). You have to take their word for it. But if they left out something important, like they take drugs and get violent, it won't usually work out.

Several subjects responded that they felt powerless in changing their financial situation, even though they ranked financial stress as one of their highest stressors. One of the three respondents who ranked financial problems as one of their highest ranked stressors said:

You get a small raise every year, it doesn't take inflation into account, but there's nothing I can do.

Distancing

Distancing is another emotion-focused coping strategy that consists of making light of a situation, refusing to think too much about it, and putting it out of your mind. It was utilized in only six percent of the situations. The feeling of lack of control to bring about change was associated with this coping strategy. Distancing was used in response to stressors such as lack of respite, problems with health professionals, lack of information, neighbors and media. For example, one subject who ranked the lack of respite as one of her major stressors, said:

Not having a vacation for over ten years...well who needs one anyway (while laughing nervously)?

Another spoke about a very difficult neighbor who gave her problems because of the residents: "I just ignore her. I don't let her get to me."

It is interesting to note that distancing was not mentioned with regard to client-related stressors such as behaviors, hygiene, medication, arguments, and medications where planned action is possible.

Self-Controlling

This coping technique, rarely mentioned by subjects, involved keeping feelings to oneself, not acting too impulsively, and rehearsing what they would say or do. Withholding thoughts and feelings and postponing action was a way to contain their feelings. About the interference with family responsibilities one operator said: "I tried to not act too disappointed that our vacation was canceled (because of no staff coverage). I had to keep working."

Positive-Reappraisal

This coping technique, rarely mentioned by subjects, is a reflective cognitive strategy which looks at growth and change. Only a few residential care operators reported learning unique ways of handling a problem or unique situation, especially with regard to personal stressors such as respite ($n=2$) and attending to family responsibilities ($n=1$).

Accepting Responsibility

This coping strategy, utilized in 1% of the situations, incorporated blaming and criticizing the self, and the realization that they may have created the problem. One subject reflecting on a patient who had left the home and committed suicide said:

I wonder if I could have noticed (his depression), I thought that I could have done better. I hope this never will happen but if it does I'll be more alert.

Summary

Similar to professionals, residential care operators mentioned direct, problem-focused coping strategies when dealing with client-related stressors, whereas emotion-focused strategies were used more frequently to tolerate uncontrollable environmental and personal stressors associated with their work.

5. What are the types and sources of social support identified by residential care operators?

Support Types for Specific Stressors

The frequencies of types of support associated with the highest ranked stressors that were mentioned by residential care operators are shown in Table 4.8. Overall, instrumental support was mentioned the most frequently (58%) for a wide range of caregiver stressors. Next, informational or cognitive (20%) types of support were mentioned. Closely following, feedback support was mentioned with a frequency of 18% across all stressors. Lastly, emotional support was mentioned for only 4% of responses for dealing with the highest ranked stressors.

Support Sources for Specific Stressors

In addition to the types of social support, the interview data provided information concerning the potential range of sources of social support. Table 4.9 provides a list of the sources of social support and

Table 4.8

Types of Social Support Used for Specific Stressors

Caregiver Stressors		Types of Support		
	Emotional	Feedback	Informational /Cognitive	Instrumental
Distressing Behaviors	0	4 (13%)	8 (25%)	20 (63%)
Respite	1 (9%)	2 (18%)	0	8 (73%)
Financial	0	1 (25%)	1 (25%)	2 (50%)
Licensing	1 (13%)	1 (13%)	2 (25%)	4 (50%)
Clients' Families	0	2 (50%)	1 (25%)	1 (25%)
Hygiene	0	0	1 (50%)	1 (50%)
Health Professionals	0	1 (33%)	1 (33%)	1 (33%)
Information Lack	0	0	0	0
Staff	0	0	0	1 (100%)
Arguments	0	0	0	0
Media	1 (20%)	1 (20%)	1 (20%)	2 (40%)
Medications	0	0	0	3 (100%)
Communication	0	0	1 (33%)	2 (66%)
Family Responsibilities	0	1 (100%)	0	0
Motivation	0	0	0	0
Neighbors	0	1 (100%)	0	0
Physical	0	0	0	1 (100%)
TOTAL (TYPES): 79	3 (4%)	14 (18%)	16 (20%)	46 (58%)

the number of times the sources were mentioned with regard to their highest ranked stressors. In response to the question, "Who is the most supportive to you in dealing with this problem (highest ranked)?" These subjects relied upon themselves (e.g., "self") in 43% of the highest ranked stressful situations. Next, they mentioned other sources such as professionals (29%) and then work associates (12%) as providing support.

Self as a Support Source

The subjects mentioned themselves, not other persons, as helping them deal with a wide variety of client, personal, and environmental stressors. For example the most frequent responses to "who helps you?" were, "I have to do it myself" or "nobody is here but me." In some situations, being able to handle the situation by oneself was associated with being able to master independently a very difficult situation, "you use your skills to solve the situation." In some situations, especially in stressful client emergencies, help from others -- primarily from mental health professionals and police -- was absent but desired, indicating negative support:

In a crisis (client), you're all alone. They never happen when the social workers or nurses are available. Holidays, weekends, and the late at night are when the guys need urgent help. So it's not surprising that we have to handle these situations on-the-spot, you can't wait for anyone else.

Another operator mentioned that she not only had to rely upon herself when there was a client crisis, but professionals did not acknowledge this:

Table 4.9 Sources of Social Support for Specific Caregiver Stressors

Caregiver Stressors	Sources of Social Support							
	Spouse	Family	Friend	Work Associates	Neighbor	Professional	Self	Other
Distressing Behavior	0	1 (3%)	1 (3%)	4 (11%)	0	21 (57%)	8 (22%)	2 (5%)
Respite	3 (19%)	6 (4%)	2 (13%)	0	0	0	4 (25%)	0
Financial	0	0	0	2 (20%)	0	1 (10%)	7 (70%)	0
Licensing	2 (25%)	0	0	2 (25%)	0	0	4 (50%)	0
Clients' Families	1 (14%)	0	0	0	0	3 (43%)	3 (43%)	0
Hygiene	0	0	0	1 (17%)	0	1 (17%)	4 (66%)	0
Health Professionals	0	0	0	0	0	3 (60%)	2 (40%)	0
Information Lack	0	0	0	0	0	0	5 (100%)	0
Staff	0	0	0	2 (33%)	0	0	4 (66%)	0
Arguments	0	0	0	0	0	0	4 (100%)	0
Media	0	0	0	3 (75%)	0	0	1 (25%)	0
Medications	0	0	0	0	0	3 (75%)	1 (25%)	0
Communication	0	0	0	1 (25%)	0	1 (25%)	1 (25%)	1 (25%)
Family Responsibilities	0	0	1 (33%)	0	0	0	2 (66%)	0
Motivation	0	0	0	0	0	0	2 (100%)	0
Neighbors	0	0	0	0	0	1 (50%)	1 (50%)	0
Physical	0	0	0	0	0	1 (100%)	0	0
TOTAL (SOURCES): 123	6(5%)	7 (6%)	4 (3%)	15 (12%)	0	35 (29%)	53 (43%)	3 (2%)

The mental health team usually calls me a few days later, after I took a client to the emergency room to be rehospitalized. It's like I'm giving them a report, after I had handled the emergency myself.

Another operator mentioned herself as her own support in the absence of support from others:

I stayed up all night to make sure she didn't leave the house. The police wouldn't take her to the hospital because when they come she told them nothing was wrong with her. Then she stayed up all night, afraid, talking about demons, thinking I was a demon.

Support Sources

After subjects relied upon themselves, they next mentioned professionals (29%) as being supportive for all of the highest ranked stressors. Also, they relied upon work associates for support (12%). The subjects did not as frequently rely upon family (7%), spouses (5%), or friends (2%) for these highest ranked stressors. Other sources were mentioned infrequently (2%) and in two cases operators were assisted by clients who helped them monitor another client's disturbing behavior; for example, other clients helped the operator with a hypomanic client who was giving away the operator's furniture to strangers. Neighbors were never mentioned as giving support to these operators with any of the highest ranked stressors.

Types of Social Support from Different Sources

The specific types of social support with frequencies from different support sources are shown in Table 4.10. The categories of support were adapted from the coding scheme developed by Norbeck, Chafetz, Skodol-Wilson, and Weiss (1991) for family care of psychiatric

patients. The results of the coding scheme is shown on Table 4.11. Using the support codes and definitions on Table 3.6, most codes, originally generated from family caregivers, were applicable to this sample's data. However, the codes "coping" and "perspective" were not identified in the process of data analysis. Further, a new category "client intervention" was developed as a new category.

Table 4.10 gives a visual representation of how different support sources differentially provide the major types of support: emotional, feedback, informational, and instrumental.

For all of the highest ranked stressors, professionals were mentioned the most frequently in providing instrumental, informational, and feedback support. As seen in Table 4.10, different sources were described as providing different types of support. For example, while professionals gave more assistance with direct client intervention, work associates, gave none. Work associates, however, helped operators in negotiating systems, such as licensing or the mental health system, or were meeting their needs by representing them at the state level to lobby for changing licensing regulations. They also provided feedback and cognitive support.

Families helped with the actual tasks of caregiving and with providing time-off or respite for subjects. In fact, family members provided much assistance with the day-to-day operation of the home. Thus, even though families are not mentioned often as supports with the highest ranked stresses, they are part of the business operation and are actually de facto employees. However, family are assumed to be involved in the business and thus were not mentioned as supporters.

Table 4.11

Comparison of Support Categories of Residential Care Operators and Family Caregivers^a

<u>Type of Support</u>	<u>Original Categories</u>		<u>New Category</u>
	<u>In This Sample</u>	<u>Not In This Sample</u>	<u>In This Sample</u>
Emotional			
Acceptance		x	
Commitment		x	
Social Involvement		x	
Affective	x		
Mutuality	x		
Feedback			
Affirmation	x		
Listening	x		
Talking	x		
Informational/Cognitive			
Illness Information	x		
Behavior Management	x		
Coping		x	
Decision	x		
Perspective		x	
Instrumental			
Client Intervention			x
Resources	x		
Respite	x		
Care Help	x		
Back Up	x		
Household	x		

^a From Norbeck, J., Chafetz, L., Skodol-Wilson, H., & Weiss, S. (1991).

While spouses were not mentioned as providing informational support or direct client intervention, they were mentioned as helping with household activities and respite. Perhaps residential care operators assume that families are always present, and thus take their assistance for granted. Although only a few spouses were mentioned, they were the only support source mentioned as providing emotional support, and they also gave feedback support.

Types of Support: Category Summaries

Examples illustrating each type of support for each category by different support sources (see Table 3.6) will be discussed in this next section with verbatim interview statements by the residential care operators and a brief description of each type of support category.

Emotional Support

Emotional support referred to caring, trust, and concern which conveyed that the person is cared for and loved. This category of support was infrequently mentioned and only in regard to spouses, with no examples from other sources.

Affective. Affective support consists of information which leads the person to believe that they are genuinely cared for and loved.

Example about a spouse: When I get upset about this situation my wife tells me she knows how hard it is to deal with these things. She tells me that she appreciates me and the things that I do. I know that she care and that gives me the strength to get through these times.

Example about another spouse: "I know he cares about me and loves me."

Mutuality. Mutuality is a support type which includes supportive, reciprocal exchanges. This, too, was mentioned by one subject's spouse.

Example about a spouse: I talk with my wife because we have mutual concerns in all that we do. I tell her what I think, she listens, and she tells me what she thinks. It's like sharing what is happening, and then I can get back to work again.

Other emotional support categories, described by family caregivers (Norbeck, et al., in press) were not identified in the data. For example, the acceptance of the caregiver despite social stigma was not relevant to residential care operators since stigma was not a stressor that was experienced by these subjects. Commitment to sharing the stress of caregiving was not expressed by these subjects, perhaps indicating that residential care operators view their role as less encumbered by the burden of caregiving than families. They did not express the expectation that others will share their stressors or become committed to the well-being of their residents. Finally, social involvement, or social contacts and companionship was not mentioned by these subjects as a type of support with regard to their highest ranked stressors.

Feedback support

Subjects mentioned how others offered validation and affirmation about how they were doing and ideas for resolving difficulties. A major theme associated with this type of support was being able to share with others who understood because having experienced similar problems. These support persons offered constructive criticism, reassurance, and encouragement. Also, they validated their perceptions about the mental health system and licensing. These categories of support include affirmation, listening, and taking.

Affirmative support. A.S. was reflected in validation of the action, feelings, and decisions of residential care operators.

Statements of affirmation were mentioned with regard to various sources, first from professionals and then spouse, family, friends, and peers.

Example about a mental health professional: Feedback about how well you're doing does not spontaneously come forth in this job, so we have a consultant (mental health professional), that helps us make sure we are doing a good job. But it's not just problem-solving difficult situations but more importantly she tells us how we are doing a good job.

Another example about a mental health professional: She knows how things can get with clients, especially the very difficult ones. So she goes out of her way to tell me that I have done a good job. So it seems that the staff are appreciative.

However, while affirmation support from professionals was a pleasant surprise, it was not often received:

Some (professionals) tell you you're doing a good job. They appreciate your efforts. But for the most part, encouraging words are left out because, I suppose, we're just expected to do our job.

Several operators mentioned that the primary source of affirmation is from oneself:

You have to give yourself a pat on the back, like making sure a person takes a bath at least once a week is a big accomplishment. Most of the time they (professionals) don't care or they don't know.

Listening. Listening refers to active listening by a supportive person who provides a sounding-board to bounce ideas off, and allows the expression of the stresses of caregiving. Residential care operators mentioned that mental health professionals, work associates, and spouses provided this support.

A mental health professional example: She knows the clients as well as I do and she will listen to my ideas and I can discover what I need to do next. It helps to have another person to sort through things.

The theme of listening associated with understanding the person was mentioned with regard to other residential care operators and family.

Example about another residential care operator: I call her up and rant and rave about the things that have happened and she'll understand while other people go, why don't you just quit that job?

Example about a mental health professional: She is willing to work on difficult (client) problems with me. We bounce off ideas and she'll work with me on coming up with a plan for what I need to do next.

Talking. Talking is a support category where the quality of active listening, emotional presence, or the feeling of unburdening about stressors was not readily apparent in the analysis of this data. Nevertheless, statements about communicating with another person were noted.

Example about another residential care operator: I talk with her every morning. She is one of my contacts with the outside world.

Example about a spouse: I tell her and she lets it go in one ear and out the other.

Informational or cognitive support categories

Illness information, behavior management, and decision making were the three subcategories of informational support. Interestingly, mental health professionals and work associates were the only two support sources mentioned with regard to these types of support.

Illness information. This is a type of support that considers the nature of the client's illness, care and supervision.

Example about mental health professionals: I told her that he had changed. She (nurse) told me the medication side-effects and we figured out what was happening. He is very sensitive to his medications.

Example about another residential care operator: I mentioned that a social worker was bringing this guy (client) here for an interview. She (another residential care operator) told me that he (client) had recently left another home -- violent or something. Then I knew what questions to ask (the S.W.).

Behavior management. Behavior management was another important type of informational support. Primarily mental health professionals were mentioned as providing this type of support.

Example about a mental health professional: She could anticipate what would happen next, and then make a list of what to do - like try this, if it doesn't work try that. She coaches me until I am comfortable in dealing with it.

Decision-making. Decision-making consists of help with problem-solving difficult caregiving problems and included suggesting concrete solutions to these problems. Other residential care operators and mental health professionals provided this type of support function.

Example about other residential care operators: She helped me decide what to do with this guy. She said to call the social worker, then take him (client) to the emergency room.

Example about another residential care operator: She agreed that I should stand-up to licensing (when they had been unreasonable). After we discussed a plan she supported my decision to consult with CARCH (state organization of licensed residential care operators).

Instrumental support categories

Instrumental support categories involved, direct, tangible assistance with stressors and was mentioned most frequently ($n=46$). A variety of subcategories of instrumental support utilized in coding the data includes assistance with direct client intervention, helping with caregiving tasks, locating resources, providing respite, providing back up, and helping maintain the household.

The subcategory of direct assistance with client issues, called "client intervention" for coding purposes, was generated in the analysis of these data and was the most frequently mentioned type of instrumental support. Client intervention is defined as another person becoming directly involved or taking action with regard to clients' behavior or

treatment. For example, mental health professionals came to the homes to assess and talk with clients.

Examples about positive support from mental health professionals:
She comes and assesses the client here to find out if he needs to go into the hospital.

and

She responds quickly, comes here, and she evaluates the patient and can get emergency help to come.

Intervention with clients, especially in client emergencies were of great importance. Although it is mentioned as an essential support need, more than half of the subjects complained about a lack:

Example about lack of support from mental health professionals:
It was Friday when we called the clinic. We told the social worker that G. was hallucinating and suicidal. He knows G. but he said he would come and see him next week. Nobody would help so we spent the weekend on pins and needles.

Assistance with the actual tasks of caregiving (e.g., care help) in the home included monitoring activities, observing behavior of clients, and setting limits was provided mostly by family, friends, or other operators.

Example about a spouse: She is a nurse and so she can sort out when a patient may be having a severe side-effect or may become symptomatic. This is invaluable because you need to observe the little changes to prevent the big emergencies.

Example about a family member: She'll come over and observe what's going on. She'll say, "I think it's time for him to see the doctor."

Resources. Resources refers to assistance with locating resources, negotiating systems, or advocating for needs. Work associates or other residential care operators were identified as the major supporters in this areas, especially with licensing stressors. Mental health professionals had access to necessary treatment facilities and crisis systems.

Examples about other residential care operators: He has influence at the state level goes to Sacramento and goes head on opposing bills that are against us or encourages legislators to introduce bills that will help us.

Example about mental health professionals: If you can get a hold of her, and most of the time she returns your phone call in ten minutes, then she can get access to emergency services faster than we can. That's a big help, it's just the times when she's not in.

The lack of respite was the second ranked stressor, but respite support was a dilemma. Operators mentioned family and friends as the only available sources of respite to provide coverage in the home and care of clients. They mentioned how difficult it is to find qualified persons who would be willing to come and stay on a twenty-four hours a day basis. One operator said: "It is almost impossible to find a responsible person who will come stay for a few days." Another operator said: "They tell me that they admire my work but they don't want to come and take care of these residents. I think being afraid is at the heart of their refusals." Further, the pool of available persons who can cover is limited by licensing regulations. One operator said:

You used to be able to just call a friend or family member to come in, but now they need to be finger-printed and have a criminal record clearance. That's O.K. but it requires a lot of time and paperwork.

Example about family members of the residential care operator: We can trust them with the residents. They come and take care of things for 3 days.

Example about a spouse: The only way we can get time away is to take separate vacations. My doctor told me that I have to get away so my husband stays here. I feel guilty but I have to get away.

Back up. Backup or assistance that is readily available when needed was mentioned as an invaluable instrumental support. Several comments were made about family members and another residential care operator as "back up people" who they could depend upon on short notice.

Comments concerning back up support were, "you know that they're always there in case you need something, they help me out." However, more comments were expressed about the need of back up than the actual availability of it.

Example about emergency help: When he started to bang his head against the window, there was nothing I could do, so I called 911 and they took him to the hospital.

However, it is not always easy to get help in an emergency:

About a situation with the police: The patient is hallucinating and threatening to kill himself, and of course its on a holiday, so I called the police and when the police came, he told them 'nothing is wrong'. The police didn't listen to me and the patient didn't get any help.

Household support. This is another kind of instrumental support.

It refers to help with maintaining the house such as housecleaning, grocery shopping, and repairs. The residential care operators mentioned this support very infrequently with regard to their highest stresses. However, when they did, family and friends helped them. For these subjects, household tasks is part of their job description and was not mentioned as tremendously difficult, but were assumed to be basic and required by the role.

6. What are the support needs identified by residential care operators?

Support Needs

Residential care operators were asked an open-ended question:

"What supports are lacking or needed to help you in your work?" and

"What supports would you recommend?" In this section the support needs

are organized according to the support types, emotional, feedback, informational, and instrumental as described by House (1981). One subject summarized the necessary sources of support:

Basically, first you have to have your family behind you. Then your other operators are your sounding board. Then we need ongoing communication with mental health (professionals).

Emotional support

Emotional support was mentioned as a basic need by most subjects.

Emotional support specific to the job was not only affection from the family but also acceptance of some of the drawbacks of the job:

They (family) know this is a part of the job so when you cancel your family plans because of an emergency, it's good to know they'll understand.

Support from other residential care operators, who were often mentioned as not only as coworkers but friends, was another source of emotional support. Other operators had a unique understanding and capacity for empathy and mutuality in supportive interactions, especially with sharing similar situations with clients, licensing, and the mental health system.

You can get stuck in this house; so if you don't reach out to others, you can be alone. I have a good friend who is an operator and she will say: "I know what you mean" and that's reassuring. I do the same for her.

Feedback support

Feedback from mental health professionals and licensing were mentioned as support needs. The responses from operators focused on the need for positive feedback about their job performance and efforts. Operators commented that positive feedback from mental health professionals and licensing were rare:

Well, before (supplemental services), I didn't get any feedback or reinforcement from any source. You'd give yourself a pat on the back for a job well done, or you might have to wait along time to hear that from anyone else.

Another operator said:

You have to do it yourself. Like with licensing they cannot say, "a job well done." This is a directive that they have from their legal department, saying that if this is part of the public record, the operators can use this in a court action against them. This makes good legal sense. And yet a good word is so important. If they would only say, "hey you screwed up here, your kitchen looks chaotic, but you're handling difficult clients, and you're working miracles with this one guy."

Informational support

The three major areas of needed support in this area were continuing education, clear expectations, and respectful two-way communication.

Residential care operators reported a perceived need for education about clients' illness, care and supervision, as well as business administration. An operator who has been in business for over 20 years said:

When the patients first arrived in our homes (years ago) we had to do our best. But as the years have gone by the patients have changed, the younger ones on drugs, the medications have changed, the (licensing) regulations have changed. You have a lot to keep up with and no where to get this.

Other operators mentioned the county mental health as potential resources for education:

The county places their clients here but they need to give more information about types of mental illness and information on how to deal with clients.

Another:

Community support programs for residential care operators and clients is the biggest support need. We need seminars and the clients need community activities.

Clear expectations and guidelines about the licensing requirements was a need. One operator who had a difficult situation with licensing

went to her an organization for residential care operators and mentioned that she did not receive the assistance she needed:

They (the peer organization) told me to work it out with licensing. That's really no help because I feel that if those who are in authority are telling me what to do, who am I to challenge that? I have no one behind me or in front.

Operators expressed the need to learn state licensing expectations. However, one operator cautions:

Check it our very carefully to get all the information you need, but with licensing it isn't what they tell you, it's what they don't tell you, and if you don't know what to ask you'll be in deep trouble.

Two-way communication or exchange of information with mental health professionals about clients was mentioned as lacking. Operators not only mentioned the need for information from professionals (discussed in the former stress section), but also the need for two-way communication. It is not just receiving information but having the opportunity to collaborate with professionals:

It is important to get input (from professionals) on a consistent basis, not waiting until something happens. But it's surprising sometimes they believe what the client says over what the operator says, in fact they don't ask us.

Another said:

They should listen to you because you are the one living with them. But there's no good team work.

And another offered a solution to the problem of communication:

We should be part of the team. The primary people, the best people, with the best information are the people who are living with somebody 24 hours a day. Most of the psychiatric evaluations are done on the basis of history and you've got to have reliable history. Not just because the client tells you some story.

The absence of communication seemed to be a barrier to effective client care and interfered with the development of mutual positive regard and opportunity for feedback. One operator said:

If they only would trust our assessment; we know these persons; we live with them 24 hours a day, 7 days a week. We can see the changes. One problem is that you have to see the relapse coming on. When it becomes apparent, we can no longer reach them, then things get out of hand.

And,

A lot could be gained from being considered as part of the team. We have just been 'an address' that they send patients to. Now with the supplemental services program we can get together with other operators and county people to discuss patients.

Instrumental support

Direct assistance in helping with client crises, improving financial resources, and provision of respite were expressed as major support needs. Also advocacy for the needs of residential care operators were mentioned.

The lack of direct and timely back-up from professionals for dealing with acutely psychotic, agitated, and potentially dangerous clients was mentioned by almost all subjects. This lack of support is summarized by several operators.

You live with these extremely difficult situations and you have to wait until they (clients) do something (dangerous) before other people get involved. They wait until something happens, then they rush in for the rescue, sometimes too late.

And when mental health professionals do not help early on:

The end result is to call 911. They have to get that bad before you get any help even when you can see the decompensation earlier. There is no support in an emergency.

And sometimes the police do not help in an emergency:

It's so frightening when nobody will come and support you. Even when you call the police department you have to call them several times before they will pick the guy up. They don't pick them up unless they see themselves that the person is a danger and so they do nothing. We need someone who is on duty 24 hours a day for 7 days a week who knows the patients and who we can call in emergencies.

Subjects expressed the need for staff and had a sense of professionalism with regard for the work that they do:

It's not the cleaning and cooking, almost anyone can be trained to do that. It's being able to be comfortable with my residents, and then to let one know if they don't eat, or if they are starting fights at the table. I need to know these things.

And

I have been cooking and cleaning now for over 8 years and now that I am graduating (psychiatric technician program), I would like to like someone to do these things. My skills go beyond the household tasks.

Adequate financial reimbursement is a support need. Several operators in mentioning the lack of adequate compensation suggested that since the responsibilities of the residential care home was similar to hospitals, compensation should be reevaluated. One operator proposed a creative solution to the lack of compensation for operators:

The government needs to support the operators. We are not given the benefits of an ordinary job that doesn't require 24 hour care, 7 days per week. We should have vacations, holidays but we're not given benefits. They say that we are in business for ourselves, but these are county clients! And we don't get anything. We should be thus treated like county personnel because we are looking after their clients and it costs hundreds of dollars per day when they are in the hospital.

Another operator comments:

The state expects improvements, perhaps the state could give low interest loans so I can build on to my home.

The lack of adequate financial support is related to the inability to hire staff and thus provide time-off from the job. One operator said:

We need more compensation to run a 24 hour facility, not so much for the operation but for the provision of staff. They don't pay you enough to be able to afford staff.

Another issue related to reimbursement for caring for difficult patients is that the payment is reduced when a client gets better. An operator reports:

That's ridiculous to put a lot of time into someone who is difficult and then they get better and they want to reduce the fee.

Inadequate financial support from the government is another need mentioned by almost every operator. One operator said:

I don't mean that money is going to necessarily but this service, but certainly that's going to have to be there in order to provide. And unfortunately, it's a very expensive deal.

The lack of financial resources was not only a concern for operators but for clients too.

I think they need to get paid more pocket money. They also need to have more workshops, places where they can earn money and have something for them to do as meaningful activity for them, some kind of employment. They also need to have more different types of housing and managers there. They also need to have some kind of emergency transportation and they need to have a psychiatric evaluator to come out to the homes in times of crisis.

Concern with respite was finding competent people to take over in their absence. Getting someone to help to get away was critical.

It would be good if we had a pool of...a resource where the residential care home operator could call up and say, "I am going to be gone for two weeks. Would you send someone over to be here in my place?"

Another major area of lack of support is in the advocacy of residential care operators' needs. The need for advocacy through involvement in county programs and peer organizations was mentioned. Although over two-thirds of these subjects were members in a residential care facility organization, they emphasized the need for changes that benefit residential care from financial reimbursement issues, reasonable regulations, to improving services for residents. For example:

We have to be actively involved in legislation that impacts residential care. This means writing politicians and making our needs known.

and

Being a member of one of our organizations is a start. Not only can you be involved in the peer program but you can have input into legislative issues.

and

Supplemental services (county program for supporting operators who have difficult patients in their homes) has been very supportive but all operators need to be involved in such programs.

The lack of support from government and society was a theme throughout the interviews. Operators commented on the general lack of concern that people have for residential care. For example:

We take people out from the streets, feed them, and give them a room, a home, and nobody cares. There was always the promise that the support system would follow the mentally ill into the community; it has not. In the 30 years, it has not come to us.

In summary, the highest ranked stressors correspond with the unmet support needs of the operators. The subjects expressed the need for: assistance with dealing with difficult client behaviors and crises; support for maintaining their business operation; and advocacy. It was not just financial support but they expressed the desire for respectful and collaborative relationships with professionals.

7. What specific factors correlate with social support and caregiver stressors such as personal and demographic characteristics of the residential care operators and facility characteristics?

First, the social networks, including network composition and characteristics, will be discussed. Then, correlations between demographic characteristics with social support and caregiver stressors will be presented.

Social Network Composition

The NSSQ gives the composition of the subjects' network by source. A general overview of the social network composition of residential care operators is shown on Table 4.12. The first four support categories

account for 89 percent of the total number of network sources with family and relatives comprising over half (55.7%) of the total network sources. In contrast, health care providers, counselor/therapists, and clergy contributed less than 1 percent of these subjects' networks.

Work associates, or other residential care operators, on the average comprised 12 of the network sources. Although this percentage is relatively low, more than sixty percent of the subjects listed a minimum of one other operator whom they considered among their network members.

Social Network Characteristics

The NSSQ provides descriptive data concerning network size, frequency of contact, and duration of relationships, and network loss, network composition, and total functional support. This study's findings were compared with a normative, employed adult sample (Norbeck, Lindsey, & Carrieri, 1983; Norbeck, Lindsey, & Carrieri, 1984) on Table 4.13. The size of the network was determined by asking subjects to list all of the persons in their network on the NSSQ. The number of members listed in their networks ranged from 3 to 22 with a mean of 10.47 and standard deviation of 3.97. The range of network persons is comparable to the Norbeck et al. (1983) sample. The duration of relationships are comparably longer with the Norbeck et al. (1983) sample, with subjects in this study's sample reporting the average per person duration of relationship of 5 years or more. Also, the residential care operator group on the average had more frequent contact, 4.20 (weekly to daily contact) as compared to the 3.62 (monthly to weekly) Norbeck et al.

Table 4.12

Overview of Residential Care Operators' Social Networks

Source of Support Category	Total Number of People for Entire Sample	Percent of Number Listed	Cumulative Percent
Spouse	25	6.22	6.22
Family/Relatives	224	55.72	61.94
Friends	60	14.93	76.87
Work Associates	49	12.19	89.05
Neighbors	13	3.23	92.29
Health Care Providers	20	4.98	97.26
Counselor/Therapist	2	0.50	97.76
Clergy	4	1.00	98.76
Other ^a	5	1.24	100.00
TOTAL SAMPLE	402		

^a Network members in "other" category include an ex-husband and clients.

Table 4.13

Means, Standard Deviations, and Range of Scores for Residential Care Operators and the Group Comparison

NSSQ Variables	Group on the NSSQ			Comparison Group ^a					
	Residential Care Operators (n=39)			Males (n=47)			Females (n=89)		
	M	SD	Range	M	SD	Range	M	SD	Range
Number in Network	10.47	3.97	3-22	11.85	6.24	3-23	12.39	5.09	2-20
Duration of Relationships ^b	50.27	20.11	12-109	51.81	29.23	11-99	54.70	22.71	10-100
Frequency of Contact ^c	43.97	16.34	13-90	44.02	23.89	8-94	44.84	18.31	8-92
Recent losses ^d	0.21	0.41	n/a	0.37	0.49	n/a	0.44	0.50	n/a
Total Functional Support	186.97	80.67	40-434	193.71 ^e	--	66-557	206.84 ^b	--	43-567

^a Norbeck, Lindsey, & Carrieri, 1983^b Based on ratings for each network member on a 5 point scale ranging from 1=less than 6 months to 5=more than 5 years^c Based on ratings for each network member on a 5 point scale ranging from 1=once a yr or less to 5=daily^d Score represents dummy coding of 0=no and 1=yes^e Norbeck, Lindsey, & Carrieri, 1984

(1983) study. Further, this sample reported, on the average, fewer recent losses from their networks. Overall, the total functional support (e.g., sum of the three functional subscales of affect, affirmation, and aid) indicates the quality of support perceived as available by residential care operators networks, and are comparable to the normative group of subjects.

Correlational Analyses

Pearson correlations are used to examine the relationships between the selected demographics, social support, and stress variables. Due to the small sample size ($N=40$), a level of significance of 0.05 was selected. Although this study's small convenience sample places limitations on the generalizability of these results to a larger population, these results nonetheless suggest provisional relationships and suggest hypotheses for future study. In the following discussion, there is a description of the statistically significant relationships among the variables of this study's research questions.

The correlations among emotional support, instrumental support, total functional support (i.e., the sum of the three functional subscales of affect, affirmation, and aid), total network characteristics (i.e., the sum of the number of members listed in the network, the duration of the relationship and the frequency of contact between the subject and network members), the total number of persons in their network, total score of the Caregiver Stress Questionnaire (i.e., total stress) and its subscales, client-related stress, environmental-

related stress, and personal stress with continuous, individual demographic variables are presented on Table 4.14.

Both tenure and age were significantly correlated with social support variables. The more years in being a residential care operator, the higher the perceived instrumental support and total functional support from their networks. Similarly, the older the residential care operator was, the greater the perceived emotional, instrumental, total network support, and number of persons in their network. However, tenure was the only demographic variable that was significantly related with stress ($r=.37$, $p=.05$). The more years a person was in the residential care business, the greater the environmental stressors (e.g., problems with mental health professionals, licensing regulations, and financial matters). This finding suggests that over time the stressful aspects of the role are those elements of the work that constantly and persistently occur and yet are the most resistant to change.

Several demographic characteristics were associated with social support and stress variables. Gender, specifically being female, is significantly associated with perceived social support. The gender of residential care operator had significantly different group means with perceived support (Table 4.15). Females ($n=30$) as compared to males ($n=9$) reported more emotional support, total functional support, and total network support. Also, they reported more network members ($M=11.20$) as compared with males ($M=7.89$). However, these results should be reviewed with caution because of the small number of males in this sample.

Table 4.14 Correlations Among Demographic, Social Support, and Caregiver Stress Variables

Demographic Variables	Emotion Support	Instru-mental Support	Total Functional Support	Total Network	Number in Network	Total Stress	Client Stress	Environ-mental Stress	Personal Stress
Age	0.46**	0.35*	0.44**	0.36*	0.34*	-0.15	-0.28	0.09	-0.16
Number of Children in Home	-0.22	-0.09	-0.19	-0.09	-0.09	0.18	0.24	0.05	0.17
Number of Adult Relatives in Home	-0.24	-0.09	-0.20	-0.23	-0.27	0.19	0.23	0.09	0.15
Number of Relatives who Work in Home	-0.18	0.05	-0.12	-0.16	-0.14	0.23	0.17	0.20	0.25
Number of Paid Staff	-0.16	0.03	-0.11	-0.17	-0.13	0.03	-0.01	0.02	0.13
Hours Worked Per Week	0.30	0.09	0.25	0.30	0.29	-0.10	-0.12	-0.08	-0.05
Total Years as Residential Care Operator	0.28	0.37*	0.32*	0.21	0.19	0.17	-0.03	0.37*	0.20
Years Education	-0.23	-0.21	-0.23	-0.18	-0.17	0.11	0.08	0.19	-0.03
Number of Residents in Home	-0.19	-0.00	-0.14	-0.21	-0.18	0.04	0.01	0.02	0.11

Note: The p-values shown are 2-tailed values. Sample size is 40. * $p < .05$; ** $p < .01$

Table 4.15

Relationship Between Gender of Residential Care Operators
and Select Variables

	Female (n=30)	Male (n=9)	t	p
<u>Variables</u>				
Total	M=201.40	M=138.89	2.31	0.04
Functional Support	SD=79.38	SD=68.49		
Total	M=112.63	M=78.11	2.56	0.02
Network Support	SD=38.66	SD=34.48		
Emotional	M=145.57	M=96.00	2.52	0.02
Support	SD=58.91	SD=49.50		
Number Listed	M=11.20	M=7.89	2.48	0.03
in Network	SD=3.85	SD=3.41		

Note. Probability is based on two-tailed, independent t-tests.

Home ownership, or whether the residential care operator owned or was buying the house, had significantly different means with two social support variables (Table 4.16). Those operators ($n=27$) who owned their home as compared to non-home owners ($n=13$) perceived more functional network support and instrumental support. Although it is uncertain, a plausible interpretation of these findings is that operators who own or are buying their homes may have greater access to their established network members who offer them emotional, affirmation, and aid support. Two demographic variables, tenure or total years of being a residential care operator and age of operator, are significantly correlated ($r=.50$, $p=.001$), indicating that while these two variables are moderately intercorrelated, yet they are two distinct variables.

8. What are the associations among stressors, social support, somatic health, and psychological well-being?

The NSSQ provided information regarding social support and the Caregiver Stress Questionnaire provided information regarding the stressors. As discussed in Chapter IV, the data from the Somatic Health Questionnaire and Bradburn Morale Scale were excluded from the statistical analysis due to low alpha coefficients. Thus, for the purpose of this correlational analysis, the three subscales of the Caregiver Stress Questionnaire and variables from the Norbeck Social Support Questionnaire were examined.

Table 4.16

Relationship Between Home Ownership and Select Variables

	Home Owner (n=26)	Not Home Owner (n=13)	t	p
<u>Variables</u>				
Total	M=205.58	M=149.77	2.50	.02
Functional Support	SD=86.66	SD=52.08		
Instrumental Support	M=59.35 SD=23.34	M=39.85 SD=17.28	2.93	.01

Note. Probability is based on two-tailed, independent t-tests.

Social Support and Stress

The correlation matrix of social support and caregiver stress variables are on Table 4.17. As expected, the different social support variables derived on the NSSQ, whether they are emotional support, instrumental support, or total functional or network support, are highly intercorrelated with each other, resulting in statistically significant correlations, thus indicating that these variables tap into the same concept of social support. Also, all of the stress subscales are intercorrelated with total stress. The stress subscales are moderately intercorrelated indicating that they are conceptually related yet separate indicators of stress.

Of interest, client stressors were significantly correlated with several social support variables. Those residential care operators who reported higher degrees of emotional support, instrumental support, total functional support, and more members in their networks perceive client-related issues as less stressful. Or conversely those subjects with a lower degree of social support find clients' behaviors more stressful. Therefore, as the degree of support increases, the study subjects' perception of client-related stressors decreases. Thus, this suggests that persons with less social support may be more likely or vulnerable to experience client-related stress.

Health

Although the questionnaires assessing the health of residential care operators were not included in this correlational analysis, some interesting anecdotal data emerged in the interview process. Overall,

Table 4.17 Correlations between Social Support and Caregiver Stress Variables

Variables	2	3	4	5	6	7	8	9
	Instru- mental Support	Total Function Support	Total Network Support	Number in Network	Total Stress	Client Stress	Environ- mental Stress	Personal Stress
1. Emotional Support	0.84***	0.98***	0.95***	0.94***	-0.23	-0.38*	-0.05	-0.04
2. Instrumental Support		0.91***	0.79***	0.78***	-0.16	-0.30*	0.03	0.06
3. Total Functional Support			0.94***	0.93***	-0.22	-0.39*	-0.02	-0.01
4. Total Network Support				0.99***	-0.19	-0.30	-0.05	-0.03
5. Number in Network					-0.19	-0.31*	-0.06	-0.02
6. Total Stress						0.93***	0.86***	0.78***
7. Client Stress							0.67***	0.65***
8. Environmental Stress								0.55***
9. Personal Stress								

Note: All correlations have 37 degrees of freedom. The p-values are 2-tailed values: * $p < .05$; ** $p < .01$; *** $p < .001$

residential care operators describe themselves as being in good health. They see themselves in a service-oriented job and value being able to function optimally. Two themes emerged from the descriptive data. First, these subjects did not report being involved in health promotion behaviors such as exercising (e.g., walking) and diet. Also, several operators mentioned having medical problems such as high blood pressure, diabetes, and cardiac problems but their evaluation of their health status on the physical health questionnaire was reported as "good" (65%) or "better than average" (17.5%). Thus, these subjects may minimize their health problems and therefore research techniques need to be formulated to assess adequately these subjects' health.

CHAPTER V

DISCUSSION AND CONCLUSIONS

This final chapter discusses and summarizes the major findings of this study, its significance, limitations, implications for clinicians who work with residential care operators, and directions for future research.

Findings

Sample Characteristics

The purpose of this study was to describe the stressors associated with the role and mediating resources--including coping strategies and social support--of residential care operators who live with and care for adult mentally ill persons, and to examine the possible associations between stressors, social supports and residential care operators' level of physical health and psychological well-being.

The subjects of this study were a relatively heterogeneous group of 40 licensed residential care operators aged 29 to 77. These residential care operators on the average have a higher level of education ($M=13.5$) as compared to operators in Segal and Aviram's (1978) original study but similar to the more recent follow-up study (Segal, Hazan, & Kotler, 1990). Additionally, over half of this study's subjects were members in an association for residential care operators or participated in a county supplemental services program sponsored by community mental health departments.

The data were collected in interviews using an in-depth, focused interview schedule, complemented by standardized questionnaires.

Content analysis, and descriptive and correlational statistics were used to respond to the research questions.

Role Dimensions

This study examined how residential care operators perceive their roles. Since little is known about these subjects, Litwak's (1977; 1985) conceptualization of family and formal organization roles provided an appropriate framework for analyzing the residential care operator's role dimensions. The subjects' roles were complex and ambiguous because of their need to function along three dimensions as surrogate family, professionals, and business persons. They expressed the least amount of ambiguity with their business tasks where role expectations are known and oftentimes routinized. For some operators, the family-like role is less certain because there are few socially defined rules that define relationships with clients. Despite this ambiguity, however many operators in this study established their own boundaries to deal with affective aspects of their relationships with clients and living in close proximity to clients. The greatest difficulty was related to their ambiguity associated with their professional-like tasks. Vague directives and the lack of information from professionals contributed to a sense of uncertainty for residential care operators. Downward communication or lack of communication with mental health professionals further intensified this role strain.

Stress

The subjects of this study experienced client-related problems as their greatest stressors, which is consistent with family psychiatric caregivers (Chafetz & Barnes, 1989; Grad & Sainsbury, 1963; Thompson & Doll, 1982). Client-related stressors ranged from potential threat of violence toward others, to suicidal thoughts, and to difficulties with daily communication. Similar to family caregivers, residential care operators expressed concern about client stressors that were related to exacerbation of acute psychotic symptoms which could result in major crises.

However, there were important differences in the significance of acute psychotic symptoms to residential care operators, compared to families described in published reports. Exacerbation of psychotic symptoms was stressful because it could trigger intense behaviors in other clients. It was not only the kind of potential stressors, but the number of stressors that contributed to distress in these subjects. This is to say that the potential was greater for simultaneous crises occurring with more than one client. Residential care operators in this study reported a high degree of stress associated with multiple, simultaneously occurring stressors that taxed their existing resources.

When compared to family caregivers, "negative" symptoms such as the lack of motivation, had comparatively less stressful impact on residential care operators. The subjects seemed to have a more realistic perspective concerning the limitations of their clients, and thus had more realistic expectations. This resulted in reduced expressions of stress, as compared to family caregivers. Subjects'

statements reflect a cognitive approach and a biological orientation for the understanding of mental illness. This may in part explain the experiencing less frustration with these client behaviors than families.

Affective reactions to client-related stressors were qualitatively different than those reported by family caregivers. The subjects in this study did not express the major themes that are in the family burden literature (Kint, 1971; Rose, 1983). For example, this study's subjects did not report concerns of families such as fears about their relative's prognosis or future. Also, although residential care operators expressed the importance of maintaining positive relationships with their clients, they did not report disruptions in their interpersonal relationships with clients as a stressor. Thus, residential care operators perceived client problems in a more cognitive manner, while families in a study using a similar caregiver stress questionnaire, expressed more emotional affect, such as feelings of disappointment, loss, and grief with regard to their relatives (Chafetz & Barnes, 1989).

Similar to families, these subjects reported the need for respite from their caregiving responsibilities. However, residential care operators expressed confinement not related to the emotional burden reported in the family caregiver literature (Thompson & Doll, 1982; Potasznick & Nelson, 1984), but concretely expressed the need to hire staff so that they could get relief from their job responsibilities. Because of the lack of staff, these subjects expressed "being strapped to the job". Additionally, these job responsibilities and unexpected changes in clients' behavior could interfere with their own family plans

for recreation or vacations, resulting in further increasing the need for respite.

Although financial pressures were mentioned as the major pressure of residential care operators in Blaustein and Viek's (1987) study, the subjects in this study did not rank financial pressures as their most severe stressor. Rather, these subjects did rank financial problems as a moderate stressor. Additionally, their inability to hire staff to assist with caregiving tasks was also a stressor related to finances.

Other environmental pressures imposed by licensing regulations, clients' families, and mental health professionals were reported as stressors. While licensing and families mostly made demands of these operators, these subjects reported that mental health professionals did not give adequate and complete information concerning significant client problems and needs. In this sample, problems with neighbors were not reported as a major concern, perhaps since these operators had already established homes and were not dealing with neighbors with regard to zoning issues.

Stress and Total Years as a Residential Care Operator

Demographic characteristics (including age of residential care operators) were examined in relationship to stressors. Those operators who were in business for a longer period of time experienced a higher degree of environmental stressors as indicated by their ratings on the Caregiver Stress Questionnaire. It was not the age of the residential care operators, but the years in business that was significantly associated with stress. There are two plausible explanations for this

finding: (1) this may indicate that over time, operators with greater experience reported increased stress related to the constant, persistent, intractable problems in dealing with mental health professionals, licensing regulations, and financial issues or (2) those operators in this sample that have less exposure may be qualitatively different. Although no studies exist on the effects of experience over time on residential care operators' stress, it is interesting to note that in this sample, only the bureaucratically generated stressors such as licensing regulations and mental health professionals were associated with tenure as a residential care operator. Within role theory perspective, the greatest role strain thus may occur in situations where power, communication, and decision-making are in the hands of high-level administrators. Further, such conflicts inherent in continuing control by a hierarchy of authority in the face of rising expertise by caregivers may contribute significantly to stress.

Coping

The subjects of this study primarily utilized problem-focused coping strategies with their highest ranked stressors. Problem-focused coping strategies (e.g., planful problem-solving, seeking social support, and confrontive coping) ranked the highest and accounted for seventy-seven percent of all of the coping strategies reported. The tendency was to directly and purposefully solve complex problems that require immediate action especially with client crises where timely, on-the-spot solutions are necessary. Then if the problem was not resolvable, support was sought primarily from mental health

professionals. Emotion-focused coping strategies were utilized by these subjects to a significantly lesser degree. These emotion-focused coping strategies were used in response dealing with chronic, persistent environmental and personal stressors.

The subjects of this study demonstrate the ability to solve problems with reflective thought and action as they contemplate possible alternative solutions and their consequences. Thus, in terms of role dimensions, they act similarly to professionals. However while their role functioning is similar to professionals, residential care operators' competence may be largely unrecognized by mental health professionals and society in general.

Social Support

The social networks and social support of the residential care operators were comparable to a normative sample of nonclinical, employed adults (Norbeck, Lindsey, & Carrieri, 1983). The total functional support reported by the subjects of this study indicates that the quality of support is comparable to the normative group. However, the duration of relationships was comparatively longer and with greater frequency of contact. The recent loss of network members experienced by subjects was fewer than that of the comparison group.

There was a relationship between supportiveness of the social network of residential care operators and their level of perceived client stressors. Those who had greater support and larger networks perceived a lower degree of client-related stress. Thus, this finding supports House's (1981) assertion that social support may provide a

direct effect reducing stress. For example, supportive network members can minimize the potential negative effects of client-related stressors through affiliation, acceptance, and accurate appraisal of self and the environment, resulting in the reduction of the potential threat posed by situations.

During the interviews, in discussing their supports for important stressors; the subjects often indicated that they relied upon themselves, that they were their own major source of support in dealing with their greatest stressors. Although reliance on oneself for support does not fit within definitions of social support, this self-reliance theoretically represents two different phenomena: self-reliance by choice (e.g., a sense of competency or mastery) and self-reliance by because of the lack of support (e.g., by default). Those operators who chose to deal with a particular problem expressed a sense of competence in being able to cope with the situation by themselves. However, in some situations, operators reported dealing with stressors alone because of the unavailability of supportive persons, most frequently they mentioned that mental health professionals were needed to assist with clients' crises.

Professionals, however, were mentioned after reliance on "self" as providing support in dealing with difficult stressors, followed by other residential care operators, and lastly family and friends. Professionals primarily provided informational and instrumental support regarding clients. In addition to informational support, other operators were resources concerning the advocacy within the mental health and governmental systems. Family and spouses provided assistance

with caregiving tasks and respite. Spouses were mentioned as the sole source of emotional support.

Support Needs

Although residential care operators turn to mental health professionals for support, they expressed that their greatest lack of support was primarily from these persons. Residential care operators expressed the need for improved client follow-up and emergency back-up support from mental health professionals. They also expressed the desire for collaborative, respectful relationships with mental health professionals especially with regard to individual client's needs. Additionally, they mentioned the need for current information about mental illness, behavior management, and medications. From both professionals and licensing regulators, they wanted clear expectations for client care and licensing standards.

Health and Well-Being

The subjects' level of physical and psychological adaptation were excluded from this study's statistical analysis. The internal reliability coefficients for this study's questionnaires measuring these concepts were lower than the acceptable standard. However, it is interesting to note that while these subjects rated their health as "good" or "above average", about twenty-five percent of these subjects anecdotally reported chronic medical problems such as hypertension or diabetes. Thus, these subjects gave incomplete disclosures of their health status. It may be that social desirability (e.g. being healthy

is associated with their being able to work) may have influenced their responses.

Significance

This study is the first to provide descriptive data on how residential care operators perceive their roles and their greatest stressors, their associated coping strategies, and their sources of social support. These findings give some beginning knowledge about the experiences of these subjects.

Residential care operators face an inherent conflicts related to the complexity of their roles. They incorporate family-like behaviors into their relationships with clients while focusing on business tasks that are a necessary and essential requirement of their work. Further, they experience ambiguity related to the professional dimension of their role. Specifically, the lack of client-related information and lack of professional involvement concerning clients is stressful. This stress is due to their lack of inclusion in the mental health system. While they express the need for improved relationships with mental health professionals, relationships with mental health professional were frequently reported as absent or noncollaborative.

The importance of client related stressors to residential care operators was confirmed in both the qualitative and quantitative data analyses. The two methods of analysis corroborated the significance of client-related problems as being perceived as the most stressful for these subjects. This is an important finding since it is assumed in the literature that financial pressures are the greatest stressors for

residential care operators. Although adequate financial remuneration is essential, it is not sufficient. These subjects identified their primary concern is with the management of acutely psychotic behaviors. These client-related stressors were not only a stressor in their own right, but compounded by the number of complex clients for whom residential care operators assume responsibility.

This study contributes to knowledge about coping theory. How residential care operators cope with particular stressors associated with their work is situation specific. That is, specific coping strategies were associated with different types of stressors. In this study there were patterns of coping strategies used for different stressors. The subjects took direct action in dealing with client-related situations and utilized cognitive processes directed at lessening their emotional distress in situations that are most unlikely to be amenable to immediate change. Thus, strategies are specific to the demands of the situation and to what may be effective in dealing with that it. Thus, these study results reveal that coping strategies are utilized flexibly and with relevance to dealing with specific types of stressors.

This study contributes to knowledge of social support. For example, the level of social support was the most critical factor associated with the mitigation of client-related stressors. Those operators with greater support reported less client-related stressors. Further, similar to coping strategies, the sources and types of social support were specific to the situation. While family provided affection, feedback in the home; other residential care operators and

mental health professionals were sought for dealing with complex business or client-related problems.

Limitations

A cross sectional design was chosen for this study's to obtain rich qualitative data about subjects and in an area where relatively little is known. Further, this voluntary, convenience sample purposefully selected persons who were licensed and therefore connected with mental health agencies. However, this creates a bias toward selection of residential care operators that are more socialized into a professional-oriented style. Also, this study's subjects have a high level of education. Thus, this study's sample may represent a unique subset of the population of residential care operators.

The instruments pose some limitations. Since no existing instruments were specific to residential care operators, this study adapted and used an existing family caregiver stressor questionnaire to measure residential care operator stressors. Tools used to measure the specific problems identified in this study, and measures for psychological health and well-being experienced by residential care operators need to be further developed. Regarding stressors, an instrument not based on family caregiving, specifically addressing unique stressors of residential care operators elicited in the interview (e.g., home safety, fire setting, staffing issues, multiple simultaneously occurring crises, and lack of personal privacy). Also, the low internal consistency found in this sample's on the physical health and psychological well-being questionnaires suggests that there

is a need for the development and testing of health outcome instruments that more validly measure the concepts of somatic and psychological health which are more sensitive to this population.

The limitations of this nonrandom, convenience sample allow generalization only to other residential care operators in this geographical area that have similar characteristics to this sample. Thus, replication of this study with other samples of residential care operators would build upon and extend this study's findings.

Implications for Clinical Practice

Several aspects of the research findings have important implications for nurses working with residential care operators and for policy makers concerned with long-term care of chronically mentally ill persons. Knowledge about specific stressors, coping strategies, and social support needs may help nurses to more effectively plan programs to alleviate or diminish stressors.

Specific stressors were more salient for different groups of subjects in this sample. For example, total years as a residential care operator was significantly associated with experiencing a higher degree of environmental stressors such as problems with licensing regulations, finances, and professionals. This has implications for directing professional support to those operators who have been in business the longest, to prevent or ameliorate the chronic, persistent negative aspects of the job that may cause the greatest role strain over time and subsequent burn-out. For example, improved communication with mental health professionals concerning clients, and increased input into

legislation that influences funding and regulation of residential care facilities, might evoke necessary changes to diminish or alleviate these environmental stressors.

This study provides a preliminary picture of how residential care operators cope with the multiple stressors involved in their jobs and suggests intervention strategies that might be useful for clinicians to use. They identify the specific areas where clinicians' intervention would be most useful. For example, these results suggest that direct and concrete assistance would be most useful if targeted to help residential care operators deal with specifically with client-related stressors.

Supportive strategies designed by clinicians such as team-building strategies and techniques that are targeted to enhance ongoing communication between mental health professionals and residential care operators and more responsive assistance by mental health professionals is suggested by this study's findings. For example, community support models that include primary caregivers such as residential care operators may increase more supportive relationships with mental health professionals, and may better connect these operators with essential support services.

Future Research

The present design allowed the researcher to describe stressors, coping strategies, and social supports as well as to examine some relationships between demographic characteristics, stressors, and social support in a sample of residential care operators. Future research

could be designed to include larger more representative samples. This study should be conducted using other samples with different ethnic compositions, educational levels, and environmental conditions such as licensing regulations (e.g. in other states) and mental health systems. Additional research would significantly expand the knowledge base concerning residential care operators.

An important extension of the present study would be the long-term effects of stress, coping styles, and social support on the health and well-being of residential care operators. The use of a longitudinal design to evaluate fluctuations and changes at several points in time would increase the possibility of studying these dynamic processes of stress, coping, and social support.

The finding that years of residential care operator experience is related to the reporting of environmental stress presents an opportunity for intervention studies. Such studies would be essential to ascertain the effects of an intervention program to help mitigate the undesirable effects of stressors on residential care operators over the long term. Such programs might include advocacy and negotiation strategies to influence policy changes that are beneficial to residential care operators and their clients.

Despite the critical functions provided by persons in this essential care giving position, little is known about these operators. For example, in-depth exploration of how residential care operators interpret and enact their various roles, and how they manage the associated role strains is necessary. Questions needing to be further explored including how do residential care operators make decisions

about the different aspects of their roles; how do they cope with the complexity and ambiguity of their roles especially with regard to their dealing with the professional aspect; how do they prioritize and balance tasks; how do role choices affect clients; how does the distress and support experienced by the residential care operator affect the support given to clients and the home environment in which care is delivered?

There is evidence of a relationship between social networks and social support and stress in this study; the possible mechanisms of social support associated with the experience of stress needs to be further examined. There was evidence in this study that these subjects perceived adequate support from their networks. Replication of this study with other samples of residential care operators, especially with other groups where their social network structure may be different, conceivably would allow further examination of relationships between study variables and specific types of networks. Questions of interest include how do residential care operators utilize support from their own families and mental health professionals; experience stressors with regard to perceived availability of social support; and perceive their health in context with their stresses and supports?

In a sense, the descriptive data from this study generates as many questions as it answers. The findings substantiate that residential care operators experience significant stressors in their work with clients who live in their homes, and social support plays an important part with mitigating the effects of stress. This study contributes to the understanding of the complexity of the role and how residential care operators utilize professional-like approaches to solving problems that

they are confronted with in their work. In addition, these subjects rely upon themselves for dealing with their most challenging situations. Finally, this study emphasizes the need to further investigate a wide variety of dynamics to better understand the stress and mediators of an important group of caregivers.

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APPENDIX A

Letter to Potential Research Subjects

APPENDIX A

Letter to Potential Research Subjects

Dear Residential Care Operator,

I am a doctoral student in nursing who is conducting a study of the concerns and needs of residential care operators. I am interested in learning about their experiences in living with and seeing to the day to day needs of mentally ill persons. For this reason, I am planning to call persons like yourself who are listed as a residential care operator. I would like to take this opportunity to briefly describe my project and ask you to participate.

I would like to meet with you to ask some questions about your experiences and concerns in providing a home for adult mentally ill persons. The interview takes about one hour and a half. During this time you may decline to answer any questions or decide what you want to discuss. I will also record the interview if you give permission.

Your confidentiality will be maintained. No individual names will be used in any reports or publications resulting from this study. Information obtained will only be available to the researcher. The data will not be used for any other purposes. This research is not associated with licensing or any other governmental agencies.

I will phone you soon to explain more about the study and to answer any questions you have and hopefully set up a time when we can get together. Although there is no personal benefit for your participation, I hope that through this study the many factors which affect residential care operators and their need for support services will be better understood. You will be reimbursed \$20.00 for your time and effort. I hope that you will be able to participate.

Sincerely,

Lou Ellen A. Barnes, RN, MS
Doctoral Student
University of California,
San Francisco
School of Nursing

APPENDIX B
Interview Introduction

APPENDIX B

Interview Introduction

I. INTRODUCTION

A. Introduction to the study and consent form.

B. Brief discussion of the purpose of this study:

I am a doctoral student who is interested in persons who live with and care for mentally disabled individuals. I have worked on research projects concerning family caregivers of adult schizophrenic and elderly persons. Little attention has been directed toward finding out the concerns and needs residential care operators experience in their jobs. Recently a survey found that there are fewer residential care facilities available for mentally ill persons in San Francisco. This is a serious health care problem. For this reason, I would like to better understand the major concerns or stresses that you experience in your job and the things that help you deal with them.

C. Opening question:

Would you tell me how you happened to get into this work?

APPENDIX C
Demographic Information

APPENDIX C

Interview # _____
Date _____ Location _____

Demographic Information

1. Your Sex: 1) Male ____; 2) Female ____
2. Your Age: _____ Birthplace: _____
The number of years you have been a residential care operator? ____
Length of residence in neighborhood: _____
Do you own this home? 1) Yes ____; 2) No ____
3. Your Current Marital Status: 1) Married ____; 2) Divorced or
Separated ____; 3) Widowed ____; 4) Never married ____
Age of Spouse: _____ Spouse's Employment: _____
4. The Number of Your Children Living with You: _____ Ages: _____
5. The Number of Other Family Members Living in Your Home: _____
6. The Number of Paid Staff that Work in Your Home (Not Including
Family Members): _____
7. If Any Staff, What Jobs Do They Perform? _____
8. Your Current Job Title: _____
9. Other Jobs that You Have Currently: _____
10. Other Jobs that You Have Had in the Past: _____
11. Your Years of Schooling: _____
12. Field of Study or Specific Training or Skills: _____
13. Are you attending a support group? 1) Yes ____; 2) No ____.
If yes, what kind of group is it? _____
14. Some residential care operators in California are receiving
supplemental funds for difficult patients. Do you receive any of
these funds? 1) Yes ____; 2) No ____
15. Your Economic Resources: (check one)
____ 1) Not enough income for needs
____ 2) Barely enough income for needs
____ 3) Adequate income, but no frills
____ 4) Adequate income, and some frills
____ 5) More than adequate income
16. Your Ethnic Background: (check one)
____ 1) Asian ____ 3) Caucasian ____ 5) Native American
____ 2) Black ____ 4) Hispanic ____ 6) Other _____

APPENDIX D

Description of Residential Setting

APPENDIX D

Description of Residential Setting

1. HOUSEHOLD ENVIRONMENT QUESTIONS

- A. Tell me about the environment in which you work. How would you describe your home?

Appearance of residence: 1) Homelike 2) Institutional

Neighborhood description: 1) Urban 2) Suburban

2. DESCRIPTION OF THE SOCIAL ENVIRONMENT

1. How many residents live in your home?

2. What are the resident's ages?

3. What are the HOUSE RULES for residents?

Rules about guests or visitors: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about how time is spent: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about food or eating: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about personal cleanliness: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about smoking: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about housekeeping chores: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about curfews: 1) Yes ___ 2) No ___
If Yes, please explain: _____

Rules about use of alcohol and street drugs: 1) Yes ___ 2) No ___
If Yes, please explain: _____

4. Do residents' family members visit? 1) Yes ___ 2) No ___
If yes, how often do they visit? _____

5. Do residents' friends visit? 1) Yes ___ 2) No ___
If yes, how often? _____

6. Do former residents keep in contact with you?
1) Yes ___ 2) No ___

APPENDIX E
Stress of Caregiving Questionnaire

APPENDIX E

Stress of Caregiving Questionnaire

1. Think about your work these days and tell me about the problems that are of concern or most stressful for you. (List up to three concerns on the Stress of Caregiving Questionnaire.)
2. I have a list of problems from the literature and the problems that you just mentioned on this list. Please rate all of the problems on a scale from 0 to 6. Circle 6 for the most stressful problems for you and circle 0 for problems that are not a concern for you or are not stressful at all to you. Problems that are moderately bothersome would be rated as the number 3. You can choose other numbers on this 0 to 6 scale according to how stressful they are for you.

Stress of Caregiving Questionnaire

The list of problems listed below are problems that residential care operators may experience in taking care of residents. The three problems that you have mentioned have been added to this list.

Please rate the degree of stress that each problem causes you these days by circling the number that best describes with the level of stress that you experience.

No	Minimal	Mild	Moderate	Severe	Extreme	Worst Possible
Stress	Stress	Stress	Stress	Stress	Stress	Stress
0	1	2	3	4	5	6

- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| 1. _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Problems with distressing behaviors such as suicidal thoughts, self-harm, or threats of violence toward others. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Problems in trying to understand or communicate with residents. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Problems with residents' physical complaints or medical illnesses. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Arguments or disagreements between residents. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Problems with monitoring medications. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Residents' lack of motivation, apathy, or failure to complete assigned activities. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Need for constant and close supervision. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Problems monitoring hygiene like bathing, showering, or clean clothes. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Problems monitoring activities outside of the house (e.g day-care program attendance, appointments). | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. Lack of sufficient information to provide for resident's special needs. | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Stress of Caregiving Questionnaire (continued)

- | | |
|---|---------------|
| 14. Not enough time away from demands of your job or not enough time for social or leisure activities. | 0 1 2 3 4 5 6 |
| 15. The job interferes with family or other responsibilities in your life. | 0 1 2 3 4 5 6 |
| 16. Trying to meet the demands of family members of residents. | 0 1 2 3 4 5 6 |
| 17. Trying to meet the demands of other health professionals. | 0 1 2 3 4 5 6 |
| 18. Dealing with other people's feelings about living with mentally ill persons | 0 1 2 3 4 5 6 |
| 19. Problems with neighbors. | 0 1 2 3 4 5 6 |
| 20. Newspapers and television sensationalizing or misrepresenting the residential care home industry. | 0 1 2 3 4 5 6 |
| 21. Problems with conflicting advice or directions from mental health professionals, state regulations, or licensing personnel. | 0 1 2 3 4 5 6 |
| 22. Financial pressures. | 0 1 2 3 4 5 6 |
| 23. Trying to meet the demands of licensing regulations. | 0 1 2 3 4 5 6 |
| 24. Not enough time to relax. | 0 1 2 3 4 5 6 |
| 25. Too much work for too few rewards. | 0 1 2 3 4 5 6 |

Questionnaire adapted from Norbeck, Chafetz, Weiss, & Wilson (1985).

APPENDIX F**Dealing with the Most Significant Problems**

APPENDIX F

Dealing with the Most Significant Problems

Three Highest Ranked Stresses

1. Select the three problems that are rated as the most severe.
Now I will ask you some questions about what helps you deal with these problems.

Problem Number 1: _____

Problem Number 2: _____

Problem Number 3: _____

Coping

1. For Problem Number 1, what are some of the things you do to deal with it?

Additional probes to be used if necessary:

2. People use a variety of things to help them deal with specific problems. Do you ever try to:

- A. Take the situation, person, or thing on directly, even if it was uncomfortable?

YES___ NO___

If yes, how did you do this?

- B. Put the problem out of your mind?

YES___ NO___

If yes, how did you do this?

- C. Keep your feelings to yourself?

YES___ NO___

If yes, how did you do this?

- D. Seek out someone to help you?

YES___ NO___

If yes, how did you do this?

E. Blame or criticize yourself?

YES___ NO___

If yes, in what way?

F. Wish that the problem would just go away, or try to distract yourself?

YES___ NO___

If yes, please tell me about it.

G. Try to distract yourself by doing something else?

YES___ NO___

If yes, how did you do this?

H. Find yourself planning and taking some action and work extra hard to carry it out?

YES___ NO___

If yes, how did you do this?

I. Did you change or grow as a person?

YES___ NO___

If yes, in what way?

Social SupportJ. Thinking about people both at work and outside, who would you say is the most supportive to you in relationship to dealing with Problem Number 1?

Are they a friend, colleague, family member?

How has this person helped you?_____

Is there any quality or something about this person that is especially helpful to you?

REPEAT THIS ABOVE SEQUENCE FOR PROBLEM NUMBER 2 AND PROBLEM NUMBER 3.

APPENDIX G
Experience with Caregiving

APPENDIX G

Experience with Caregiving

1. What advice would you give someone who is now going into this business for the first time?
2. What is/are the most important thing(s) for them to know in this work?
3. If you could change anything about this work, what would you change?
4. Do you plan to stay in this job?

If no, what do you plan to do? _____

(Additional probes to be used if this information has not already been elicited in the first four questions.)

5. What resources or supports would they turn to as they experience some of the difficulties that you have described?
6. Who could they depend on in an emergency such as a patient's crisis?
7. Are there kinds of information, guidance, direct help, emotional support, reinforcement, or feedback that you've needed and not received?
8. What kinds of supports would you recommend to these new operators to better assist them in taking care of residents?

Questions adapted from Norbeck, Chafetz, Weiss, & Wilson (1985).

APPENDIX H**Norbeck Social Support Questionnaire**

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS
ON THIS PAGE BEFORE STARTING.

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

Example:

First Name or Initials	Relationship
1. MARY T.	FRIEND
2. BOB	BROTHER
3. M.T.	MOTHER
4. SAM	FRIEND
5. MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- spouse or partner
- family members or relatives
- friends
- work or school associates
- neighbors
- health care providers
- counselor or therapist
- minister/priest/rabbi
- other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

For each person you listed, please answer the following questions by writing in the number that applies.

- 1 = not at all
- 2 = a little
- 3 = moderately
- 4 = quite a bit
- 5 = a great deal

Question 1:

How much does this person make you feel liked or loved?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 2:

How much does this person make you feel respected or admired?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

GO ON TO NEXT PAGE

(7-9)

(10-12)

- 1 = not at all
 2 = a little
 3 = moderately
 4 = quite a bit
 5 = a great deal

Question 3:

How much can you confide
 in this person?

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____
 10. _____
 11. _____
 12. _____
 13. _____
 14. _____
 15. _____
 16. _____
 17. _____
 18. _____
 19. _____
 20. _____
 21. _____
 22. _____
 23. _____
 24. _____

(13-15)

Question 4:

How much does this person
 agree with or support your
 actions or thoughts?

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____
 10. _____
 11. _____
 12. _____
 13. _____
 14. _____
 15. _____
 16. _____
 17. _____
 18. _____
 19. _____
 20. _____
 21. _____
 22. _____
 23. _____
 24. _____

(16-18)

GO ON TO NEXT PAGE

- 1 = not at all
 2 = a little
 3 = moderately
 4 = quite a bit
 5 = a great deal

Question 5:

If you needed to borrow \$10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

(19-21)

GO ON TO NEXT PAGE

(22-24)

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Number _____ (1-4)
 Date _____

Question 7:

 How long have you known
 this person?

- 1 = less than 6 months
 2 = 6 to 12 months
 3 = 1 to 2 years
 4 = 2 to 5 years
 5 = more than 5 years

Question 8:

 How frequently do you usually
 have contact with this person?
 (Phone calls, visits, or letters)

- 5 = daily
 4 = weekly
 3 = monthly
 2 = a few times a year
 1 = once a year or less

PERSONAL NETWORK

First Name or Initials Relationship

- | | |
|-----------|-------------|
| 1. _____ | _____ (132) |
| 2. _____ | _____ (133) |
| 3. _____ | _____ (134) |
| 4. _____ | _____ (135) |
| 5. _____ | _____ (136) |
| 6. _____ | _____ (137) |
| 7. _____ | _____ (138) |
| 8. _____ | _____ (139) |
| 9. _____ | _____ (140) |
| 10. _____ | _____ (141) |
| 11. _____ | _____ (142) |
| 12. _____ | _____ (143) |
| 13. _____ | _____ (144) |
| 14. _____ | _____ (145) |
| 15. _____ | _____ (146) |
| 16. _____ | _____ (147) |
| 17. _____ | _____ (148) |
| 18. _____ | _____ (149) |
| 19. _____ | _____ (150) |
| 20. _____ | _____ (151) |
| 21. _____ | _____ (152) |
| 22. _____ | _____ (153) |
| 23. _____ | _____ (154) |
| 24. _____ | _____ (155) |

 PLEASE BE SURE YOU HAVE RATED EACH PERSON
 ON EVERY QUESTION. GO ON TO THE LAST PAGE.

Page 6

(37)

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason?

_____ 0. No
 _____ 1. Yes

IF YES:

9a. Please indicate the number of persons from each category who are no longer available to you.

_____ spouse or partner	(58)
_____ family members or relatives	(59-60)
_____ friends	(61-62)
_____ work or school associates	(63-64)
_____ neighbors	(65-66)
_____ health care providers	(67)
_____ counselor or therapist	(68)
_____ minister/priest/rabbi	(69)
_____ other (specify) _____	(70)
	(71-72)
	(73)

9b. Overall, how much of your support was provided by these people who are no longer available to you?

_____ 0. none at all
 _____ 1. a little
 _____ 2. a moderate amount
 _____ 3. quite a bit
 _____ 4. a great deal

APPENDIX I
Health Questionnaire

APPENDIX I

Health Questionnaire

Now I'd like to ask some questions about your health. These questions come from a standard list so some of them may not be relevant to you. Please answer them as they apply to you.

1. How would you rate your health in general? (Do you have any particular problems?)
1) Excellent___ 2) Good___ 3) Fair___ 4) Poor___
2. How does your health compare to other people your age?
1) Better___ 2) About average___ 3) Worse___
3. How often does your health get in the way of what you want to do?
1) Never___ 2) Sometimes___ 3) Frequently___
4. Are you concerned with your health these days?
1) Not at all___ 2) Somewhat___ 3) Very much___
5. Has your health changed recently?
1) Better___ 2) About the same___ 3) Worse___
6. Do you have any pain or discomfort now?
1) Not at all___ 2) Sometimes___ 3) All of the time___
7. How is your appetite?
1) Good___ 2) Fair___ 3) Poor___
8. How is your vision?
1) Good___ 2) Fair___ 3) Poor___
9. How is your hearing?
1) Good___ 2) Fair___ 3) Poor___
10. Do you have any trouble sleeping?
1) No___ 2) Sometimes___ 3) Often___
11. How would you describe your energy level?
1) High___ 2) About average___ 3) Low___

Questionnaire adapted from Johnson, C.L. (1987).

APPENDIX J

Psychological Well-Being Questionnaire

APPENDIX J

Psychological Well-Being Questionnaire

1. Taking all things together, how would you say things are these days? Would you say you are 1) very happy, 2) fairly happy, or 3) not too happy?
2. Now I want to ask you some questions about how you feel. Please tell me if in the PAST WEEK you have felt like this:

	OFTEN	SOME	RARE	NEVER
	1	2	3	4
A. On top of the world.	1	2	3	4
B. Very lonely or distant from other people.	1	2	3	4
C. That things were going your way.	1	2	3	4
D. Particularly excited or interested in something.	1	2	3	4
E. Depressed or very unhappy.	1	2	3	4
F. Pleased about having accomplished something.	1	2	3	4
G. Bored.	1	2	3	4
H. Proud because someone complimented you on something you did.	1	2	3	4
I. So restless you couldn't sit still.	1	2	3	4
J. Upset because someone criticized you.	1	2	3	4

Questionnaire adapted from Bradburn & Caplovitz (1965).

APPENDIX K

Consent to be a Research Subject

APPENDIX K

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO BE A RESEARCH SUBJECT

A. PURPOSE:

Lou Ellen Barnes, RN, MS, is a doctoral candidate in the Department of Mental Health and Community Nursing at the University of California, San Francisco. She is studying the concerns and needs of residential care operators who care for mentally ill adults in their homes. I have been asked to participate in this study.

B. PROCEDURES:

If I agree to be in the study, the following will occur:

1. I will be interviewed by Lou Ellen Barnes about my work situation and my thoughts and feelings about what it is like to be a residential care operator. This interview will be conducted at a time and place convenient to me, will take about 1 hour and will be audiotape recorded, if I agree.

2. I will be given several paper and pencil forms which will ask questions about me, my feelings, and my opinions. It will take about a half hour to complete these forms. If I wish, Lou Ellen will ask me the questions out loud and fill in the forms for me.

C. RISKS/DISCOMFORTS:

Some of the questions on the forms or in the interviews might be personally upsetting to me because I must think about difficult problems, but I've been told that the researcher is a graduate nurse who is trained to talk with people about sensitive topics. I am also free to decline to answer any question I don't wish to answer and to stop the interview at any time. I have also been told that my name will not be recorded on the forms or the interviews and that my answers will be used only for the purposes of this study. No individual identities will be used in any reports or publications resulting from the study. Interview information will be identified by a code number and kept in locked files at all times. Only study personnel will have access to the files and the audiotapes. After the study is completed and all data transcribed from the tapes, the tapes will be destroyed.

D. BENEFITS:

There will be no direct benefit to me from participating in this study. A possible benefit of this study is that this research may result in improved understanding of specific feelings, problems, and needs of residential care operators who take care of mentally ill persons.

E. ALTERNATIVES:

I am free to choose not to participate in this study.

F. COSTS:

There will be no costs to me as a result of taking part in this study.

G. REIMBURSEMENT:

I will receive \$20.00 for my time and effort in participating in this study.

H. QUESTIONS:

If I have any comments or concerns about participation in this study, I will first talk with Lou Ellen Barnes at (415) 858-1470 or her research supervisor, Dr. Linda Chafetz at (415) 476-2726. If for some reason I do not wish to do this, I may contact the Committee of Human Research, which is concerned with protection of volunteers in research projects. I may reach the committee office between 8:00 am and 5:00 pm, Monday through Friday, by phoning (415) 476-1814 or by writing to the Committee of Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California, San Francisco, CA 94143.

I. CONSENT:

I have been given a copy of this consent form to keep.

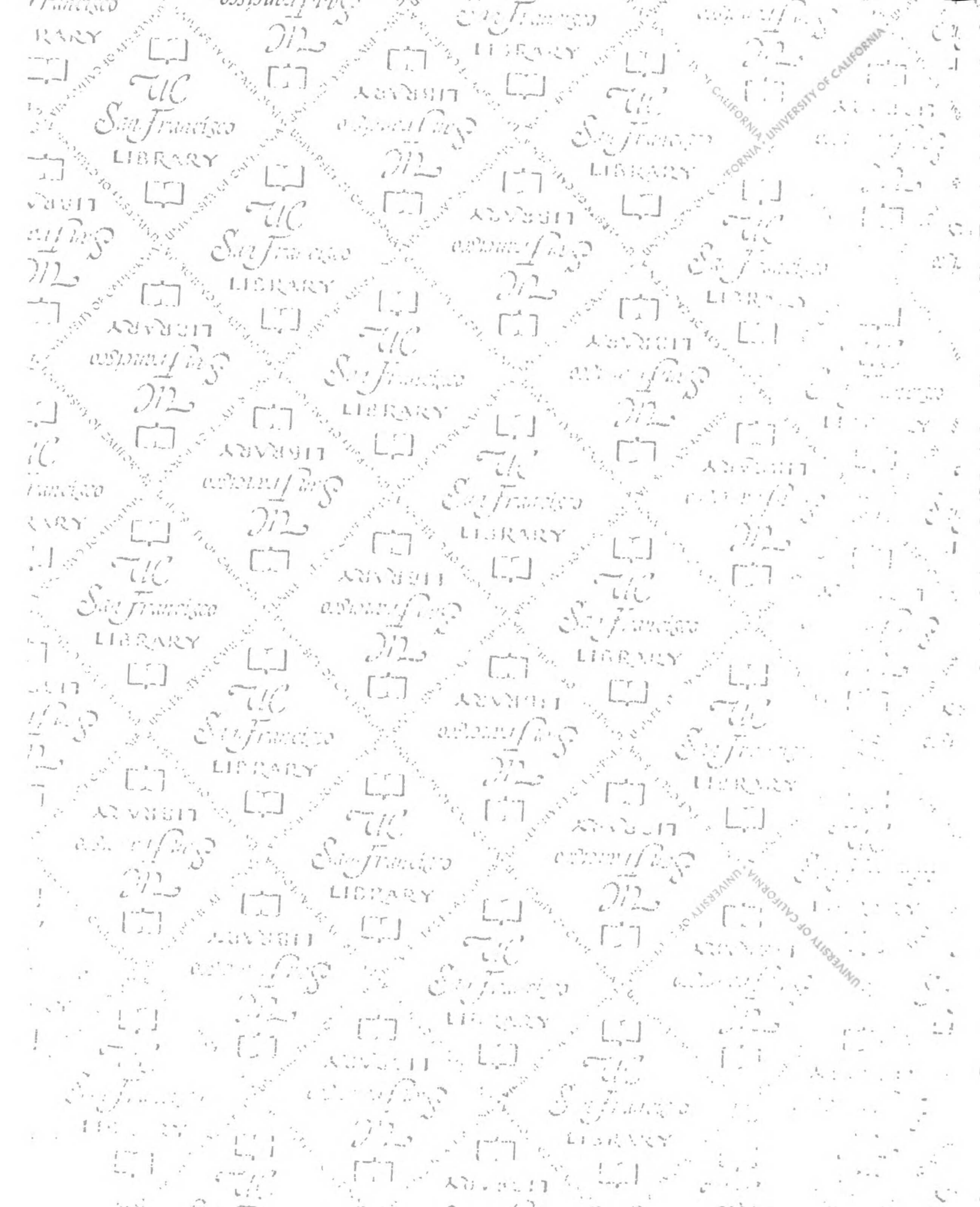
PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no effect on my work as a residential care operator or any relationship with U.C.S.F.

Date: _____

Subject's Signature: _____

Person Obtaining Consent: _____

The Committee on Human Research Approval Number for this study is:
H6164-05227-01



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