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A Stress Process Model of Family Caregiver Service Utilization: Factors Associated with Respite and Counseling Service Use

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ABSTRACT. This study examines whether caregivers' differential utilization of respite and counseling support services is associated with different situational stress processes. A multinomial regression analysis was conducted to compare respite users, counseling users, and those who used neither service, using data collected on a statewide random

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sample of 1,643 California caregivers providing assistance to individuals aged 50 or older. Compared with caregivers who used neither service, respite service users were more likely to have demanding care situations giving rise to physical symptoms of stress, and were more likely to use community services for the care recipient to augment their care. In contrast, counseling service users were more likely to be managing the meaning of their care situation by seeking out information about services and talking with a confidant about their situation, while coping with both emotional and physical symptoms of stress. Tailoring caregiver interventions to meet the support needs and coping strategies stemming from diverse caregiving situations and caregiver characteristics may increase the likelihood that those interventions will be effective in alleviating or preventing deleterious secondary stress frequently experienced by family caregivers. doi:10.1300/J083v49n04_03 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Caregiving, service utilization, stress, coping, respite, counseling, support groups, caregiver interventions, Stress Process Model, National Family Caregiver Support Program

INTRODUCTION

Family caregivers provide the vast majority of long-term care for older adults. Among non-institutionalized persons needing assistance with activities of daily living, two of three depend solely on family and friends; another 25 percent supplement family care with services from paid providers (Bengston, Rosenthal, & Burton, 1996; Liu, Manton, & Aragon, 2000). While care provision can be beneficial for caregivers and care recipients alike (Scharlach et al., 2003; Noonan & Tennstedt, 1997), caring for a disabled family member can be a source of physical strain, psychological distress, and social isolation (Pearlin, Mullan, Semple, & Skaff, 1990; Schulz & Beach, 1999; Schulz, O'Brian, Bookwala, & Fleissner, 1995).

Various programs and services have been developed to assist caregivers to cope with the demands of caregiving. The National Family Caregiver Support Program (NFCSP), for example, authorizes local

Area Agencies on Aging to provide caregivers with information, access to community services, individual and group counseling, respite, and a variety of supplementary services. However, caregiver interventions such as these typically are underutilized (Kosloski & Montgomery, 1993; Strain & Blandford, 2002), and have not consistently been shown to alleviate the physical and psychological strain that caregivers experience (Dura, Stukenberg, & Kiecolt-Glaser, 1991; Monahan, Greene, & Coleman, 1992; Russo, Vitaliano, Brewer, Katon, & Becker, 1995). Meta-analyses suggest that many caregiver services tend to produce domain-specific effects that are limited to particular types of needs and goals (Sorensen, Pinguart, & Duberstein, 2002), but which seldom are explicitly stated in service design and recruitment. Needed are conceptual models that explicate the theoretical rationale for particular types of caregiver support services, linking their use to specific caregiver coping styles or needs, so that interventions can be targeted to those that are most likely to use and benefit from them (Pillemer, Suito, & Wethington, 2003). In this study, respite and counseling services are examined to determine whether differences in caregivers' situational stress processes predict differential service utilization.

Because of our interest in developing a theoretical rationale for the use of particular types of caregiver support services and further linking their use to specific caregiver needs, this study utilized the caregiver-specific stress process model (Pearlin et al., 1990) to examine caregivers' utilization of respite care and counseling services. The caregiving stress process model focuses on interrelationships among several categories of variables (caregiving context, primary stressors, secondary stressors, and mediators) expected to impact caregiver well-being. From this perspective, utilization of support services can be understood as a coping strategy in response to particular combinations of primary and secondary stressors inherent in the care situation. The stress process model identifies three types of coping styles: (1) management of the situation that gives rise to stress; (2) management of the meaning of the situation; and (3) management of the stress symptoms that result from the situation.

To investigate the link between the stress process and the specific benefits of support service use, we specifically examine respite and counseling services because they appear to reflect the conceptually different coping strategies outlined in the stress process model. Because respite care is designed to provide temporary relief from the caregiving situation by providing hands-on care and supervision to care recipients, we hypothesize that it reflects a coping style of attempting to manage the care situation as well as its physical and temporal demands. Respite,

therefore, might be expected to have particular utility for caregivers who have especially demanding care situations and little time off. Conversely, counseling focuses primarily on assisting caregivers to alter their own perspective or adapt to the care situation; it thereby serves as a mechanism for assisting caregivers to manage the meaning of the situation. Counseling might be expected to have utility for caregivers who experience emotional distress as a result of their care situations. We draw upon the caregiving stress process model to examine the primary stressors, secondary stressors (e.g., intrapsychic and role strains), and caregiving context, which contribute to the use of respite and counseling services.

Respite Service Use

Existing evidence provides some support for the hypothesis that respite use is associated with care situations involving high levels of primary stressors, such as the personal involvement and time commitment associated with caring for someone with heavy personal care needs. Caregivers of care recipients that require help with ADLs have been found to be significantly more likely to use respite services (Braithwaite, 1998; Cox, 1997; Houde, 1998; Kosloski, Montgomery, & Youngbauer, 2001; Toseland, McCallion, Gerber, & Banks, 2002). Secondary stresses resulting from the caregiving situation, such as the caregiver's own physical and mental health problems, have been found to predict respite service use (Houde, 1998; Kosloski et al., 2001; Cox, 1997).

Contextual factors related to respite use include lack of informal support (Strain & Blandford, 2002; Kosloski et al., 2001) and increased formal service utilization by the care recipient (Kosloski & Montgomery, 1993). Respite users tend to be younger than nonusers (Kosloski, Montgomery, & Karner, 1999). Also, spousal caregivers, compared with children, are less likely to use respite care services, as they are more likely to provide hands-on care themselves (Montgomery & Kosloski, 1999). White caregivers access respite services at a higher rate (Montgomery, Marquis, Schaefer, & Kosloski, 2002), while African American caregivers use respite over a longer period of time and Latinos a shorter period of time than do other groups (Montgomery et al., 2002). The generalizability of such findings is limited by the use of self-referral or convenience samples of persons who already are accessing or interested in accessing respite services.

Counseling Service Use

Counseling services would be expected to be accessed by caregivers confronting higher levels of psychologically demanding primary stressors. Care recipient behavior problems and dementia diagnoses are associated with counseling and support group use (Toseland et al., 2002; Monahan, Greene, & Coleman, 1992). Caregivers experiencing secondary stressors, such as intrapsychic strains, are more likely to access mental health services (Rickwood & Braithwaite, 1994) and attend support group sessions (Monahan et al., 1992).

Contextual factors associated with counseling use include higher levels of social support (Rickwood & Braithwaite, 1994), especially during particularly stressful periods (Cohen, Guttman, & Lazar, 1998). White caregivers have the highest rates of counseling service utilization, while Asian Pacific Islander and Latino caregivers use mental health services at lower rates than other groups (Alvidrez, 1999; Monahan et al., 1992; Zhang, Snowden, & Sue, 1998). Counseling users tend to be female, younger, and more highly educated, compared with the adult population at large (Braithwaite, 1998; Deane & Chamberlain, 1994).

Research Questions

While a great deal of research has focused on caregivers' use of support services (Cox, 1997; Dilworth-Anderson, Williams, & Gibson, 2002; Houde, 1998; Toseland et al., 2002), no previous research has explicitly linked caregiver support intervention functions to the caregiver stress process model (Schulz, Gallagher-Thompson, Haley, & Czaja, 2000). Nor has previous research directly compared utilization of respite with counseling services. Due to the methodological limitations of previous studies and the lack of a unifying framework that adequately explains the constructs associated with caregiver formal service use, little is currently understood about the link between caregivers' characteristics, specific care situations, and the use of support services to help ameliorate the physical strain and psychological distress of caregiving.

In this study, we utilize a representative sample of caregivers to examine factors associated with the use of respite and counseling services. Using the caregiver stress process model and findings from the literature, we hypothesize the following:

1. Respite use will be associated with higher levels of physical stress symptoms and more physically demanding care situations, including those later in the care trajectory, and where there is limited informal support and greater formal support service use by the care recipient;
2. Counseling use will be associated with higher levels of interpersonal and intrapsychic stress symptoms and more emotionally demanding care situations, including those earlier in the care trajectory and where there is greater informal social support;
3. Respite and counseling users, like users of other health and social services, will be more likely than nonusers to be White and non-Hispanic, female, younger, more highly educated, and in a higher income bracket.

METHODS

Sample

Data for this study were gathered through a household survey of California caregivers conducted as part of an interagency agreement between the California Department of Aging (CDA) and the Center for the Advanced Study of Aging Services at the University of California, Berkeley to assist CDA in the implementation and evaluation of the NFCSP. The sampling frame consisted of telephone numbers of California households that were sorted into working blocks of 100 contiguous numbers, then randomly sampled within working blocks. To ensure that some unlisted phone numbers were included in the sample, the original list was supplemented by using a working number as a seed from which one other number was generated by adding a constant. Telephone interviews were conducted between March and August 2002, using computer-assisted telephone interviewing equipment and software.

The final survey sample consisted of 1,643 individuals who were providing care to someone aged 50 or over. Caregivers were identified in one in six households, comparable with national estimates that approximately 17 percent of all U.S. households with a telephone contain at least one caregiver (National Alliance for Caregiving & the American Association of Retired Persons, 2004). Ninety-eight interviews were conducted in Spanish and the remaining 1,545 were conducted in English. The survey was completed by 19 percent of identified caregivers, consistent with the

response rates of two similar national studies (National Alliance for Caregiving & the American Association of Retired Persons, 2004).

To detect sampling bias, we compared the ethnicity of all households contacted with general California figures, and we compared the ethnicity of our sample with projections of the ethnicity of California caregivers from a national study (National Alliance for Caregiving & the American Association of Retired Persons, 1997). The sample was consistent with national caregiver data and relatively representative of the California population as a whole. There was an overrepresentation of Latino respondents (25% vs. 22% in California) and an underrepresentation of Asian caregivers (5% vs. 10% in the California population).

Measures

Caregiver support service use. Respite and counseling service utilization data were derived by asking about the types of formal assistance caregivers had received within the past year. A dichotomous composite score for formal respite service use was determined by “yes” answers to any one of the three respite service questions: (1) “Have you had someone help to take care of your [Relationship] during the day in his/her home, so you can have time to do other things or relax?” (2) “Have you used a center where your [Relationship] can go during the day, so you can have time to do other things or relax?” And (3) “Have you used a place where your [Relationship] can stay overnight, so you can have time to do other things or relax?” Counseling service users were identified by “yes” answers to any of these counseling service use questions: (1) “Have you received professional counseling?” (2) “Have you received advice or counseling from a clergy person?” And (3) “Have you talked with a group of other people who are in a similar situation: such as a support group?”

Respondents who had used both respite and counseling services ($n = 129$) were excluded from the sample because of our interest in examining separately respite and counseling services in terms of the conceptually different coping strategies hypothesized in the stress process model. In addition, 206 respondents were excluded from the analyses because they had missing data regarding the type of services used.

Demographic Characteristics. Several demographic characteristics were measured: Caregiver race/ethnicity (API, Hispanic, African American, and White), country-of-origin (USA/other), gender, education (high school graduate-yes/no), age (± 50 years), income ($\pm \$30K$), and rural location (± 500 population/mile).

Caregiving Context. Data on the caregiving situation included: Primary care provider (self, other, or shared) and years caregiving (<1 year, 1-5 years, or >5 years). Other contextual factors assessed using dichotomous measures included: Caregiver relationship to care recipient (spouse or other); caregiver lives with care recipient; availability of back-up care; presence of a confidant; use of information and referral services; and care recipient use of community services in the previous month.

Primary Stressors. Primary stressor variables included: care recipient ADL care needs; IADL care needs (low, medium low, medium high, high); behavioral, memory or mental health problems; and whether ADL assistance was provided by the caregiver.

Secondary Stressors. Secondary stressors were assessed by asking whether the care situation had resulted in family conflict, financial strain, sleep disturbances, physical and/or mental health problems, or work-related changes.

Analytic Methods

Cross tabulations determined the association between service use and constructs of the stress process model, including demographic characteristics, caregiving context, and primary and secondary stressors. Association was determined using the Cramer's V statistic for nominal symmetric measures, which indicates the strength and significance of the relationship between two variables in a cross tabulation.

A multinomial logistic regression model estimated the differential effects of stress process model variables on respite use and counseling use. Only those variables found to be associated significantly ($p < 0.05$) with service use at the bi-variate level were entered into the regression equation and cases that had missing values for any of the variables included in the analyses were omitted from the analysis.

High inter-item associations were found between care recipient IADL limitations and caregiver assistance with ADLs ($V = 0.552$, $p < 0.0001$), and all care recipients with ADL limitations received caregiver assistance. Therefore, we included in the multinomial regression only the variable indicating whether the caregiver assisted with the care recipient's ADL limitations, a better indicator of caregiver primary stress. The regression was run twice, to compare respite and counseling service users with nonusers of either counseling or respite services, and then to compare counseling with respite service users.

RESULTS

Use of Respite and Counseling Services

Forty-one percent of the respondents had utilized some form of formal respite or counseling service. Ten percent used respite care only, 22% used counseling only, and 9% used both services.

Predictors of Respite Use and Counseling Use

Demographic Characteristics. As shown in Table 1, respite users were more likely than other caregivers to be: U.S.-born, African American, high school graduates, and employed part-time. Counseling service users, in comparison with respite or nonusers, were less likely to be API. Hispanic caregivers were the least likely to use respite and the most likely to use counseling compared with the other racial and ethnic groups. No significant associations existed between respite or counseling service use and caregiver gender, age, income, or rural location.

Caregiving Context. Respite users were less likely to live with the care recipient, be married to the care recipient, or have primary caregiving responsibility, and more likely to have used information about services and have a care recipient using community services. Counseling users were more likely to be married to and living with the care recipient, have a confidante to talk to regarding the caregiving situation, and to use information services. No significant associations were found between service use and the number of years of caregiving, or having a source of back-up care.

Primary Stressors. Respite users were more likely to have a care recipient with ADL or IADLs needs and to directly assist with ADL needs. Respite users also were more likely to have a care recipient with severe memory problems. Respite and counseling users were more likely than nonusers to have their sleep disturbed. Caring for someone with mental health or behavioral problems was not associated with respite or counseling service use.

Secondary Stressors. Respite users were more likely than nonusers to report physical health problems associated with caregiving. Counseling users were more likely to report having both mental health and physical health problems. Respite and counseling service users were both more likely than non-service users to report family conflict. Financial hardship was associated with both respite and counseling compared with

TABLE 1. Service Use by Caregiver Characteristics, Context, Primary and Secondary Stressors

	Respite 145 (11%)	Counseling 323 (25%)	Neither 840 (64%)
<i>Caregiver Characteristics</i>			
Born in USA **	135 (93)	277 (87)	612 (82)
Race/Ethnicity **			
Asian/ PI (1)	6 (4)	7 (2)	49 (6)
Hispanic (2)	26 (18)	85 (28)	219 (27)
Non-Hispanic Black (3)	16 (11)	18 (6)	43 (5)
Non-Hispanic White (4)	96 (67)	194 (64)	487 (61)
High School Education **	109 (75)	227 (71)	528 (64)
Employment*			
Not employed (0)	66 (46)	170 (53)	486 (58)
Part-time (1)	27 (19)	42 (13)	98 (12)
Full-time (2)	52 (36)	111 (34)	256 (31)
Age ≤ 50 years	65 (46)	154 (49)	382 (47)
Gender Male	35 (24)	73 (23)	218 (26)
Income ≤ \$30,000	43 (36)	118 (44)	274 (40)
Rural Location	36 (27)	77 (27)	163 (24)
<i>Caregiving Context</i>			
Married to Care Recipient*	10 (7)	47 (15)	95 (11)
Lives with Care Recipient***	40 (28)	108 (35)	327 (43)
Primary Caregiver ***			
Self (0)	60 (42)	185 (58)	510 (61)
Other (1)	57 (40)	92 (29)	207 (25)
Shared (2)	27 (19)	43 (13)	117 (14)
CG Info Service Use***	47 (33)	103 (32)	152 (19)
CR Service Use ***	54 (37)	85 (26)	150 (20)
Confidante to Talk to **	115 (81)	260 (81)	529 (72)
Years Caregiving			
Less than 1 year (0)	39 (27)	64 (20)	166 (23)
1 to 5 years (1)	66 (46)	169 (53)	404 (55)
More than 5 years (2)	39 (27)	86 (27)	166 (23)
Back-up Caregiver	97 (68)	212 (69)	495 (69)
<i>Primary Stressors</i>			
CG Assists w/ ADL***	48 (60)	107 (37)	214 (28)
CR Needs Assistance w/ ADLS***	87 (45)	142 (37)	284 (28)

	Respite 145 (11%)	Counseling 323 (25%)	Neither 840 (64)%
CR Needs Assistance w/ # IADLS***			
Low (0)	9 (6)	58 (18)	179 (21)
Low medium (1)	13 (9)	69 (21)	208 (25)
High medium (2)	41 (28)	89 (28)	220 (26)
High (3)	82 (57)	107 (33)	233 (28)
CR Severe Memory Problems***	70 (49)	115 (36)	267 (32)
CR Mental Health Problems	54 (38)	116 (37)	265 (32)
CR Behavior Problems	38 (26)	75 (24)	182 (22)
<i>Secondary Stressors</i>			
Family Conflict**	45 (31)	110 (35)	185 (25)
Job Strain	24 (30)	38 (25)	68 (19)
Financial Strain*	72 (50)	152 (48)	300 (41)
<i>Health Problems ***</i>			
Physical (1)	20 (14)	26 (8)	37 (5)
Mental (2)	13 (9)	35 (11)	49 (6)
Both (3)	8 (6)	31 (10)	29 (4)
None (4)	104 (72%)	225 (71%)	627 (85%)
Sleep Disturbance ***	48 (33)	98 (31)	162 (22)

p. < 0.05, ** p. < 0.01, *** p. < 0.001

non-service use. Job strain was not significantly related to respite or counseling use.

Multinomial Logistic Regression Analyses

Table 2 shows the probability of three categories of service use: Respite care only, counseling only, and neither respite nor counseling. The model was significantly different than the null model after all the statistically significant variables from the bi-variate analysis were entered into the equation in the order listed in Table 2 ($\chi^2 = 121.37$, $df = 44$, $p < 0.001$). The model explained approximately 15% of the variance in type of service used (psuedo-R²).

As shown in Table 2, respite users were nearly twice as likely as caregivers who did not use either respite or counseling services to care for a care recipient who was using community services. Respite users were twice as likely as nonusers of respite or counseling services to be assisting with ADL care demands; and over three times as likely to report physical health problems resulting from caring.

TABLE 2. Results of Multinomial Logistic Regression for Type of Caregiver Service Utilization (n = 940)

Reference Group	Respite No Service Use		Counseling No Service Use		Counseling Respite	
	<i>b</i>	Exp(<i>b</i>)	<i>B</i>	Exp(<i>b</i>)	<i>B</i>	Exp(<i>b</i>)
Caregiver Characteristics						
Born in USA	0.66	1.94	-0.20	0.82	-0.86	0.42
Race/Ethnicity:						
Asian/ Pacific Islander	0.09	1.10	-1.37	0.26**	-1.46	0.23*
Hispanic	-0.38	0.68	-0.004	1.00	0.38	1.47
African American	0.67	1.94	0.23	1.26	-0.44	0.65
White, non-Hispanic						
High School Education	0.38	1.46	0.17	1.18	-0.21	0.81
Caregiving Context						
Primary Caregiver						
Self	-0.14	0.87	-0.21	0.81	-0.07	0.93
Other	0.27	1.31	0.01	1.01	-0.25	0.78
Shared						
Married to Care Recipient	-0.51	0.60	0.49	1.64	1.00	2.70*
Living with Care Recipient	0.38	0.68	0.37	0.69*	-0.01	1.01
CR Service Use	0.66	1.93**	0.02	1.02	-0.64	0.53*
Info Service Use	0.46	1.59	0.54	1.71**	0.07	1.08
Confidante to Talk to	0.41	1.51	0.45	1.57*	0.04	1.04
Primary Stressors						
Memory Problems	0.05	1.05	-0.02	0.98	-0.07	0.93
Assists w/ CR ADL	0.69	2.00**	0.26	1.30	-0.43	0.65
Secondary Stressors						
Sleep Disturbance	0.35	1.42	0.04	1.04	-0.31	0.73
Employment						
Not Employed	-0.11	0.90	0.03	1.03	0.14	1.15
Part-time	0.55	1.73	0.18	1.20	-0.36	0.70
Full-time						
Family Conflict	-0.17	0.85	0.32	1.38	0.49	1.63
Financial Strain	0.41	1.50	0.17	1.18	-0.24	0.79
Health Problems						
Physical	1.21	3.35**	0.38	1.46	-0.83	0.44*
Mental	0.42	1.53	0.56	1.76*	0.14	1.15
Both	0.66	1.93	1.01	2.75**	0.36	1.43
None						
Intercept		-3.81***		-1.51***		2.30**

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

Counseling users were one-fourth as likely as nonusers of respite or counseling services to be API versus White non-Hispanics, two-thirds as likely to live with the care recipient, 1.7 times as likely to have sought information about services, and 1.6 times as likely to report having a confidante with whom to talk. Counseling users were 1.8 times as likely to report mental health problems and nearly three times as likely to report both physical and mental health problems than nonusers of either service.

Examining the variables that differentiated respite and counseling users showed that counseling users were one-fourth as likely as respite users to be APIs rather than White non-Hispanics and nearly three times as likely to be married to the care recipient. In addition, counseling users were one-half as likely to have a care recipient using community services and were almost half as likely to experience physical health problems related to providing care.

DISCUSSION

The purpose of this research was to examine the use of support services as coping mechanisms in helping to ameliorate the physical strain and psychological distress of caregiving. To that end, we directly compared caregiver utilization of respite with counseling services, two services specifically designed to address uniquely different situational stress processes, using the constructs of the Stress Process Model. We found partial support for the hypothesized differences between respite and counseling service use as coping responses to caregiver situational care demands.

Respite Service Users

Consistent with our hypotheses that respite use would be associated with physically demanding care situations and secondary physical stress symptoms, respite service users were more likely than nonusers to assist with ADL care demands and report physical health problems. These findings support the idea that respite use represents an attempt to obtain temporary relief from primary stresses of providing care, especially when they have accumulated to the point of physical distress. The temporary relief afforded by respite services has been shown to contribute to decreases in perceived stress, burden, anxiety, and somatic complaints, and increases in morale (Biegel & Schulz, 1998; Bourgeois,

Schulz, & Burgio, 1996; Zarit, Stephens, Townsend, & Greene, 1998; Sorensen et al., 2002). Respite services may allow caregivers to maintain their role over a longer period of time, and delay institutionalization of the care recipient (Kosloski & Montgomery, 1995).

Caregiver demographic and contextual factors (e.g., race/ethnicity, relationship to the care recipient) found to contribute to respite use in previous studies (Montgomery et al., 2002; Montoro-Rodriguez et al., 2003[v2]) did not enter significantly into our final model, when respite users were compared with service nonusers. However, when directly comparing respite with counseling users, spousal caregivers were more likely to use counseling than respite services, consistent with Montgomery and Kosloski's (1999) finding of differing patterns of caregiving trajectories among spousal caregivers and children. They hypothesized that spousal caregivers are more likely to provide hands-on assistance, and conversely, adult children are more likely to seek outside assistance (Montgomery & Kosloski, 1999).

Counseling Service Users

As hypothesized, counseling users were likely to report mental health problems, suggesting that counseling was sought to deal with emotional and psychological symptoms of the stress process. Counseling users were especially likely to report both caregiving-related physical and mental health problems. Monahan et al. (2002) found that caregivers with physical health problems tended to access counseling services at higher rates than other groups. This may reflect the tendency for emotional and psychological stress symptoms to appear as somatic symptoms (Kroenke, 2003). Also, some caregivers may delay seeking counseling until their emotional stress results in physical symptoms. Research using longitudinal data has partially supported reciprocal effects between caregiver physical illness and depression (O'Rourke, Cappeliez, & Guindon, 2003). Interestingly, Pearlin and colleagues (1990), in developing the Stress Process Model, predicted that "elements of emotional distress are likely to surface first and if they persist, they may be eventually inimical to physical well-being" (p. 590).

Other secondary stressors (i.e., family conflict, financial hardship, sleep disturbance) did not make statistically significant contributions in the multivariate analyses. However, compared with those using neither counseling nor respite, counseling users were less likely to live with the care recipient. Not living with the caregiver might create feelings of guilt

or family conflict requiring counseling services to reduce the discord between the caregiver's actions and feelings.

Pathways to Service Use

Our findings provide insights into caregiver service use pathways. Respite users were likely to be assisting care recipients who were using other community services, an association also found by others (Kosloski & Montgomery, 1993). It seems likely that care recipient service use may serve as a "pathway" for service use by caregivers, although the cross-sectional nature of our data precludes us from determining definitively whether caregiver respite use or care recipient community-based service use occurred first. The potential importance of care recipient services as an access point to family caregiver support services supports the importance of assessing caregiver needs as part of the intake process of home and community-based services for disabled older adults. The Carers (Recognition and Services) Act of 1995 in the United Kingdom, for example, allows family members to have their own needs assessed in parallel with their disabled relative (Seddon & Robinson, 2001; Arksey, Hepworth, & Qureshi, 2000).

Counseling service users were more likely to have sought information about caregiver support services, and have a confidant with whom to talk. Information seeking may reflect efforts to manage the care situation through increasing one's knowledge and skill levels. Speaking with a confidant may reflect efforts directed at managing meanings, including attitudes and emotional responses. Other studies also have found that higher levels of social support are strongly related to the use of mental health services such as counseling (Rickwood & Braithwaite, 1994), especially during particularly stressful periods (Cohen, Guttman, & Lazar, 1998). Having a confidante may reflect a greater "willingness to disclose," which extends to the use of counseling services (Vogel & Wester, 2003; Rickwood & Braithwaite, 1994). Our cross-sectional data make it difficult to conclude whether social support and information seeking represent enabling factors in counseling use or whether caregivers who like to talk about their problems with others and seek information are more likely to use counseling services. Counseling service use needs to be understood in the context of caregivers' characteristics and needs for social and emotional support. It is possible that assertive outreach efforts are required to increase access to counseling services among caregivers who are socially isolated but have unmet psychological needs.

Differential Use of Caregiver Support Services

Our findings provide evidence of differential access to and use of support services by some caregiver groups. Caregivers of API origin are significantly less likely than other groups to utilize counseling services rather than respite services. Such preferences likely reflect family norms and cultural values, as well as unmeasured psychosocial factors (Bradley et al., 2002) API caregivers with emotional needs who do not use counseling services may be receiving other sources of social and emotional support, or they may have residual unmet needs. Zhang and colleagues (1998) found that Asian-Americans preferred friends or relatives to professionals for sharing mental distress, were less likely to talk about mental problems than White Americans, and underutilized mental health services of all types. A recent survey by the National Alliance for Caregiving and AARP (2004) found that API caregivers were more likely than White non-Hispanic caregivers to report having unmet needs for help or information, and the *California Statewide Survey of Caregivers* found that API and Latino caregivers were more likely to report language as a barrier to formal service utilization than other groups (Giunta, Chow, Scharlach, & Dal Santo, 2004).

Stress Process Model

The stress process model provided a useful framework for organizing key characteristics of the caregiving situation, as they related to service use. Hypotheses regarding characteristics of respite and counseling service users were generally confirmed. Respite use was found to be associated with physically demanding care situations and secondary physical stress symptoms, reflecting its use as a strategy for managing residual physical and temporal demands of a stressful care situation. Counseling use was associated with secondary emotional and psychological symptoms, representing a strategy directed at managing the meaning of the situation. Contextual factors made relatively minor contributions to caregiver service use in the stress process model.

Our findings that the primary and secondary stressors of caregiving outweigh contextual factors in predicting service use are consistent with other studies that find "need" to be the most important predicting factor in service use (Wolinsky, 1990; Kosloski et al., 2001). Although the Stress Process Model did no better than other models of service use (e.g., Andersen Behavioral Model, Health Belief Model, Practice-Ori-

ented Model) in the amount of variance in service use it explained (Kosloski et al, 1999; Kosloski & Montgomery, 1992; Montoro-Rodriguez et al., 2003), it provided a useful mode for conceptualizing caregiver service types and their differential utilization.

The stress process model also is a useful framework for understanding the utility of other services that may function in similar ways to respite and counseling. Findings about respite use could serve as a model for other types of services that allow caregivers to manage day-to-day caregiving responsibilities (e.g., transportation, meal programs). The findings regarding counseling services could enhance understanding of the use of services that serve to change the way caregivers perceive their situation (e.g., education, information, case management).

Limitations and Future Directions

This study utilized a representative sample of California caregivers with diverse care situations and care recipient physical, cognitive, and psychological conditions, in contrast to previous research with the stress process model, which has been limited primarily to caregivers of people with Alzheimer's disease. Because these data were collected as part of a broader study of caregivers and service use, which was not specifically designed to evaluate the stress process model, some model constructs may not be represented adequately, while others (e.g., intrapsychic strain) were not assessed directly. Also, no data were available regarding the decision-making processes caregivers use to identify and select among available service options. Nonetheless, the variables appear to be plausible representations of the relevant underlying constructs and primary components of the stress process model.

The study is also limited by the cross-sectional nature of the data. Our findings suggest a complex relationship among the duration of care, support needs, and service use, which can only be examined using longitudinal data. We do not know whether the interventions that the caregivers selected were effective coping mechanisms for dealing with their symptoms, changing their knowledge or skill level, or alleviating some of the demands of care. While respite and counseling have positive impacts on the well-being of caregivers (Biegel & Schulz, 1998; Bourgeois et al., 1996; Zarit et al., 1998), it will be important in future research to examine the association among the stress process components, interventions to address residual stress, and their benefit.

Practice Implications

The study's findings that differences in caregivers' situational stress processes predict their differential utilization of respite and counseling support services have important practice implications. Caregiver interventions such as respite and counseling are underutilized (Kosloski & Montgomery, 1993; Strain & Blandford, 2002). Even when caregivers do use support services, it may only be in small increments or late in the care process. A better understanding of the characteristics of caregivers' stress processes and coping mechanisms may allow more precise targeting of service use modalities to under-served population subgroups, by maximizing existing pathways and overcoming barriers to service use.

In addition, support service interventions have not consistently been shown to alleviate the physical and psychological strain that caregivers experience (Dura, Stukenberg, & Kiecolt-Glaser, 1991; Monahan, Greene, & Coleman, 1992; Russo, Vitaliano, Brewer, Katon, & Becker, 1995). Tailoring interventions to meet the specific support needs and coping strategies stemming from diverse caregiving situations may increase the likelihood that interventions will be effective in alleviating or preventing secondary stress frequently experienced by family caregivers. Many caregiving interventions involve several treatment elements aimed at simultaneously addressing multiple problems. The need for more narrowly targeted interventions is supported by the findings from the Resources for Enhancing Alzheimer's Caregiver Health (REACH) project, which conducts research on interventions designed to enhance family caregiving for Alzheimer's disease (Schulz et al., 2003). The REACH findings support the tailoring of structured intervention components to target the specific components of the stress (and health) process.

Finally, the study findings emphasize the importance of examining explicitly the theoretical rationales underlying particular types of caregiver interventions. Because caregiver support services tend to produce domain-specific effects, practitioners and program planners would be well advised to give more attention to caregivers' specific needs and goals in their service design, recruitment, and implementation. The stress process model, with its thorough assessment of care responsibilities and the impact that those duties have on caregiver well-being, provides a useful conceptual model for beginning to identify the specific types of caregiver support services which are most appropriate for particular caregiver coping styles or needs.

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