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Korean Family Caregivers' Perceptions of Care in Dementia Care Units

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With the demanding level of care needed for people with dementia, more Korean families are institutionalizing their relatives with dementia. This presents particular concerns for the Korean culture that values family responsibility for elder care. The purpose of this study was to describe Korean family members 'perceptions of stress and satisfaction with care, the caregiving role, the family-staff relations. A purposive sample of 94 family members in 10 long-term care dementia care facilities in Korea participated in the study. Family Perceptions of Care Tool and Family Perceptions of Caregiving Role developed by Maas and Buckwalter (1990) were used to investigate Korean family caregivers 'perceptions of care. Findings from the study can be summarized as follows: a) family caregivers showed the lowest satisfaction level for staff management effectiveness, especially for facility 's resources available for care, and (b) family caregivers showed the highest stress from staff members 'control on caregiving, feeling the same responsibilities after placement, and guilt over their placement. The results contribute to the understanding of Korean family caregivers 'perceptions of caregiving and the care relationship after institutionalizing their elderly persons with dementia.

Key Words: Dementia; Family Caregiving; Dementia Care Unit

INTRODUCTION

1. Statement of the problem

Dementia is now recognized worldwide as an increasing problem brought about by the rapid growth of the elderly population. The prevalence of elderly persons with dementia in Korea's growing elderly population ranges from 6.8 to 10.8% of persons 65 and older (Kim & Choi, 2000), and this number is expected to increase spectacularly with the rapid increase of persons in that age group in Korea in next decades. During the last decade Korean society has faced many of the same challenges related to family caregiving for elders with dementia as has the western society. Traditionally, family members in Korea assume total responsibility of caregiving for ill elders. The long-standing value of filial piety that emphasizes the provision of personal care for one's parents, strongly discourages the family from accepting care services from non-family members. However, traditional family care of elders with dementia has been declining in Korea due to drastic industrialization and urbanization accompanied by rapid economic growth. The number of long-term care facilities for dementia care has continued to increase since they began to appear in the early 1990s. This trend will accelerate as the population ages and dementia increases.

Placement in a facility might provide relief from caregiving; however, this transition can result in feelings of guilt, grief, and anguish for family members (Stephens, Kinney, & Ogrocki, 1991). Although the perception exists that family involvement in caregiving ends once institutional placement occurs, most families remain committed to their relatives after nursing home placement

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(Monahan, 1995).

However, research on family caregiving for persons with dementia is rudimentary and primarily confined to studies of elderly persons living with their families. Although health professionals, policy makers, and researchers in Korea have started to recognize the issue of family caregiving of elderly persons with dementia who are residing in long-term care facilities, very little research has focused on this issue. In addition, research on Korean family members' stress and satisfaction of their caregiving and care for elders with dementia in long-term care settings does not exist in the literature.

2. Purpose of the study

The purpose of the study was to describe Korean family caregivers' perceptions of stress and satisfaction with care, their caregiving roles, their relationships with staff, and their involvement in care.

Specific research questions were:

(1) What are Korean family caregivers' perceptions of satisfaction with the care of patients with dementia provided by facilities?

(2) What are Korean family caregivers' perceptions of stress from their caregiving roles in the care of their patients with dementia in facilities?

3. Definition of terms

Dementia Care Unit is defined as a separate unit designed to the care of residents with Alzheimer's disease and other related dementias (ADRD) in a long-term care facility.

Family Perceptions of Satisfaction with Care is defined as a family caregiver's level of satisfaction with staff consideration of the family caregiver and the resident, management effectiveness, physical care, and activities provided by the facility.

Family Perceptions of Stress from Caregiving Role is defined as the level of stress from loss of aspects of the relationship with the institutionalized elders, guilt about perceived failure in caregiving, feelings of captivity resulting from obligations of caregiving, and conflict with staff over caregiving.

LITERATURE REVIEW

1. Changes in family care for elders in Korea

Many changes in familial factors under the influence of modernization have limited the Korean family's traditional function or capability to support and care for elderly members, and are contributing to the problems of aging. The average family size has decreased and thus is expected to be only 3.0 in the 2000s, which means the average married couple will have only one child. In addition, the rate of women's participation in occupational and social activities has increased from 4% in the 1970s to over 50% in the 1990s (Korean National Statistical Office, 1998). These phenomena make caring for disabled or frail elderly members in the home more difficult. Family support still remains a major source of caregiving for elders in Korea, however, the increasing portion and actual number of frail and impaired older people, other demographic changes, industrialization, and urbanization affect the capacity of family to care for older parents.

2. Dementia care units

As dementia progresses, family caregivers are often faced with a decision to place a family member in a facility. In fact, dementia is the major cause of institutionalization in the United States. As many as one third of the 1.5 million nursing home patients have (ADRD) (Bellelli et al., 1998). The probability of ADRD and long-term care facility placement increases with age. Due to these changing demographics, increasingly family caregivers will be faced with having to make difficult decisions concerning the continuing care of their family members. Placement of an older adult in a facility is a major stressor for family members and the burden of caregiving does not end after institutionalization (Dellasega & Mastrian, 1995). Common stresses tend to recur with all placements in an institution. These stresses include long-standing patterns of negative relationships among one another and problems between family members (Smith, Buckwalter, & Mitchell, 1993); changes in the family's structure and the family's interaction and relations (Drysdale, Nelson, & Wineman, 1993); and stress of the actual placement process, which is influenced by family and cultural values (Fink & Picot, 1995). Family members often experience moral conflicts and describe nursing home placement of an older adult as the most difficult problem ever faced (Butcher, Holkup, Park, & Maas, 2001; Kelley, Swanson, Maas, & Tripp-Reimer, 1999).

Once a patient is admitted to a nursing home, many staff members tend to view the family as "visitors" and may not be open to family member participation in care. Attempts by family members to continue participation in caregiving can be discouraged and resented by staff who feel that only they are in control of the patient's care. Thus, the stress they experience from loss of the former relationship with the patient, and guilt associated with placement of the patient in the nursing home is often compounded by felt obligations to continue caregiving and conflict with staff (Buckwalter, Maas, & Reed, 1997). The stress of role conflicts with family members is especially trying for staff when it is added to the stresses of task burden and feelings of inadequacy that are often experienced by staff who are caring for persons with dementia (Dellasega & Mastrian, 1995). Burden and stress evidence that caregivers need support programs or specific interventions. Identifying family members' perceptions of burden and stress may provide useful information for developing strategies to improve caregiver adaptation following nursing home placement of an elderly relative with dementia.

Family satisfaction is an important outcome variable after placement. Measures for positive as well as negative caregiver outcomes after placement are needed. The family role is central in dementia care both before and after placement and therefore the family is the client and its satisfaction should be of great concern to health care professionals. In addition, persons with dementia may not be able to express their evaluation of the quality of care verbally. The family caregiver can be the voice for quality-of-care issues. Family caregivers of relatives with dementia tend to perceive quality of services based on their satisfaction with the way services are delivered. Therefore, family satisfaction with care also can be regarded as an indirect measure of care quality, even though it is not a single optimal measure. It has been suggested to measure satisfaction in diverse domains, including environmental issues, programming, staffing, and physical, and emotional care to fully understand family satisfaction (Montgomery, 1994).

METHODOLOGY

1. Settings and sample

The study involved data collection from 10 long-term care facilities located in the southern provinces of Korea of Kyung-Sang-Nam-Do and Kyung-Sang-Buk-Do. The facilities included 6 geriatric hospitals, 2 dementia care centers and 2 nursing homes. Most of the facilities were located in suburban areas. Six of the facilities were for-profit with the remainder being not-for-profit (2) or public (2). There has not been a standardized description of what a dementia care unit should be in Korea. The facilities ranged in size from 80 to 360 beds, with dementia care units ranging in size from 15 to 120 beds. The residents were admitted to dementia care units if they have a diagnosis of dementia, confirmed by neuropsychological evaluation. The dementia care units were staffed by nurses and nursing assistants 24 hours a day. At least one registered nurse was available during day time hours on each dementia care unit. Nurses and nursing assistants were educated for dementia care by each facility according to their own policy. There were few formal training programs for nursing staff members in dementia care unit in Korea. Each nursing assistant was assigned to care for 20 to 30 patients during day time hours and 40 to 50 patients during night time hours. Additionally, staff from other departments including social workers, physical therapists, and dieticians, worked in the dementia care units on a part-time basis. The daily programs offered by the facilities included dancing, singing, drawing, and exercise which were planned specifically for the residents with dementia.

Criteria for sample selection were 1) Primary family caregivers were defined as persons who took the chief responsibility for family caregiving. To be considered a primary family caregiver, the person had to both self-identify as such and be recognized as such by a primary nurse or nursing assistant, 2) Evidence of at least monthly visits to the patient, and 3) 18 years of age or older.

The questionnaire was administered in person when the caregivers visited the facility. Caregivers preferred to fill out the questionnaires upon initial contact at the facility rather than receiving them and sending them back by mail, or answering by phone. The family members who were most closely involved with care for patients with dementia were identified by the primary nurses at the selected settings. Each facility provided a small room for data collection. Family caregivers who met the inclusion criteria were introduced to the principal investigator or research assistants and were asked if they would consent to fill out the questionnaires. A few caregivers who had difficulty reading or understanding the questionnaire were assisted by the investigators. A total of 117 questionnaires were completed, however, 23 were excluded due to missing data, leaving 94 for analysis.

2. Instruments

The self-administered instruments originally developed in English were translated to Korean by the researcher, back-translated into English by a Korean-American, and then the original English and back-translated versions were tested for content, semantic, and technical equivalence by four American nursing scholars who were involved in developing the original instruments. The discrepancies in translating and back translating the instruments were discussed with a bilingual Korean-American physician and a bilingual Korean-American nurse. For example, there was no equivalent Korean expression for "real say." Therefore, a Korean word which means "authority" was chosen. Translation and back translation was repeated until the items in both languages were evaluated as equivalent. Fifteen family caregivers in a dementia care unit were recruited to pretest the instruments. Most of their suggestions concerned the format, not the content of the instruments. This information was considered for modification of instrument format.

Family Perceptions of Care Tool (FPCT): The 51 item FPCT was developed by Maas and Buckwalter (1990) and measures four areas of family caregivers' satisfaction with care of their relative: staff consideration of family and patient, management effectiveness, physical care, and activities. Items are rated on a seven point Likert-type scale with neutral mid-point (1=strongly disagree, to 7=strongly agree). Reported Cronbach's alphas for the subscale structures were .97 for the Physical care subscale (items 37 to 44), .87 for the Activities subscale (items 14 to 16, 31 to 33), .88 for the Management Effectiveness subscale (items 7, 12, 47, 50, 51), .85 for the Consideration subscale (items 2, 8, 10, 11, 28, 35) (Maas et al., 2000). The Cronbach's alphas for this study were .83 for Physical care, .81 for Activities, .60 for Management Effectiveness, .70 for Consideration and .94 for the total scale.

Family Perceptions of Caregiving Role (FPCR): The FPCR tool is an 81 item self-report tool developed by Maas and Buckwalter (1990) to measure multiple dimensions of family member stress associated with an institutionalized relative with dementia. Items are rated on a seven point Likert-type scale (1=strongly disagree, to 7 = strongly agree). Four subscale structure were used for analyses of family caregivers' stress: (1) loss of aspects of the relationship with relatives with dementia (items 46, 47, 48, 50, 51, 53, 55), (2) guilt from perceived failure in caregiving (items 25, 26, 28, 29, and 33), (3) captivity resulting from obligations of caregiving (items 23, 34, 49, 56, 57, 59, and 61), and (4) conflict with staff over caregiving (items 1, 2, 7, 10, 11, 15, 16, 19, 41, and 54). Reported Cronbach's alphas were .73 for the Loss subscale, .70 for the Guilt subscale, .81 for the Captivity subscale, and .84 for the Conflict subscale (Maas et al., 2000). The Cronbach's alphas for this study were .83 for Loss, .74 for Guilt, .80 for Captivity, .60 for Conflict, and .94 for the total scale.

Demographic and Caregiving Characteristics: The demographic and caregiving characteristic data were collected using the questionnaire that included caregiver age, gender, education, occupation, marital status, health status, relationships to care recipient, caregiving hours and duration, and living arrangement of care recipient.

3. Data Analysis

Descriptive statistics, such as frequencies, percentages, means, standard deviations, and ANOVA, t-test, and scheffe tests were used for quantitative data analysis.

RESULTS

1. Demographic characteristics

Daughters and sons comprised respectively 27.7% of family caregivers while daughters-in-law composed 24.5% of family caregivers. The remaining relationships were spouses (5.4%) and other relatives including nephews, nieces, and siblings (14.9%). It was notable that 41% of females, and especially 42% of daughters-in-law, had full time jobs. The majority (85.7%) of caregivers were employed full time. Eighty percent of family caregivers were between 31 and 50 years of age with mean age of 61. Over half (56.3%) of family caregivers paid the facility fee privately and 36.8% of caregivers received government support. Only 6.9% of family caregivers used the residents' personal savings or pensions. More than half (55.7%) of family caregivers visited their family members 1 - 2 times, 26.1% for 3 - 5 times, 11.3% for 6 - 10 times, and 6.8% for over 10 times per month. Eighteen point seven percent (18.7%) of the caregivers had not completed high school. About resident data, over half (53.7%) of residents were below 75 years old with mean age of 75.5. In the type of dementia, residents had a high percentage of Alzheimer's disease (66.0%) and vascular dementia (32.0%). The majority (70.4%) were admitted to the present facility directly from home. The remaining residents (25.3%) also were transferred from short-term care settings to the present facilities. Both groups had never used any other community dementia care services such as home care, day care, or short-term care. Approximately thirty percent (29.6%) of residents used assistive devices and had a non-ambulatory status (24.7%). The remaining residents (45.7%) were ambulatory with or without the assistance of the staff. Mean length of stay in facility was 9 months with the range of 1 to 62 months.

2. Family caregiver's satisfaction with care

Korean family caregivers' mean scores on the FPCT were most positive on the Consideration (staff consideration of family and patient) subscale (M =5.12) and least positive on the Management (staff management effectiveness) subscale (M =3.92) (Table 1).

It was notable that the frequency of visit showed significantly negative relationships with total FPCT scale (r =-.32, $p<.01$), the Activities (r=-.24, $p<.05$), and the Consideration (r=-.30, $p<.01$) subscales. In addition, family caregivers whose residents stayed longer in the facilities, were less satisfied with physical care (r=-.26, $p<.05$). There were no statistically significant differences in mean Total FPCT (Family Perceptions of Care Tool) and subscale scores by relationship of the caregiver to the resident.

Examination of individual item means revealed that family caregivers were most dissatisfied with: 1) resources available for care (M =1.88), 2) exercise for patients (M =2.83), 3) use of patient's self care activities (M =3.47). Mean scores of each item in the subscales are

Table 1. Scores on subscales of FPCT (N = 94)

Family Perception of Care Tool	M	(SD)
Consideration	5.12	(0.98)
Management	3.92	(1.07)
Physical Care	4.19	(1.24)
Activities	4.06	(1.23)
Total	4.32	(0.83)

Table 2. Item scores for FPCT subscales

Family Perception of Care Tool	M	(SD)
Staff Consideration for Patient and Family		
2. I could feel more welcomed by staff when I visit.	5.82	(1.44)
8. Staff provide for the privacy of my family member.	4.74	(1.58)
10. Staff solicit my help in providing care for my family member.	5.22	(1.52)
11. Staff provide support to help me deal with my feelings about my family members.	5.22	(1.52)
28. I am satisfied with noise level.	5.94	(1.22)
35. I am satisfied Protection of my family member 's belongings	5.07	(1.60)
Management Effectiveness		
7. Staff tend to treat my family member as a child.	4.40	(2.01)
12. Other residents on the unit get upset with my family member 's behavior and sometimes treat him or her with unkindness.	4.66	(2.05)
47. My family member 's personal belongings are sometimes taken by other residents.	4.88	(2.14)
50. Staff do the best they can but are often too busy to give my family member the attention he or she should have.	3.79	(1.89)
51. If more resources were available, staff could provide care that would be more beneficial for my family member.*	1.88	(1.39)
Physical Care		
37. Grooming and hygiene.	4.41	(1.76)
38. Medications used.	4.61	(1.73)
39. Use of restraints.	4.34	(1.61)
40. Sensory stimulation (e.g., artwork, music, colors).	3.79	(1.92)
41. Use of self care abilities.	3.47	(1.99)
42. Bowel and bladder function.	4.09	(1.79)
43. Control of behavior.	4.42	(1.77)
44. My input into the care provided.	4.30	(1.90)
Activities		
14. My family member gets enough exercise.	3.98	(1.49)
15. My family member should be encouraged to participate in more activities*	2.83	(1.86)
16. Enough activities are provided for my elder.	4.53	(1.62)
31. I am satisfied with opportunity for physical exercise.	4.90	(1.65)
32. I am satisfied with number of staff resources to provide care.	4.09	(1.80)
33. I am satisfied with opportunities for my elder to enjoy the outdoors and other diversions.	4.04	(1.97)

*reverse scored item

described in Table 2.

3) Family caregiver's stress of caregiving role

Mean score on the FPCR subscales was highest for loss (of the positive aspects of their relationship with the care recipient) (M = 4.74). The next highest scores were for the Guilt (from perceived failure in caregiving) (M = 4.70), followed by Captivity (resulting from obligations

Table 3. Family perception of caregiving role: comparisons by relationship

Relationship (n)	Conflicts (F_4=.67)		Loss (F_4=.25)		Captivity (F_4=.47)		Guilt (F_4=3.86*)		Total (F_4=.85)	
	M	(SD)	M	(SD)	M	(SD)	M	(SD)	M	(SD)
Spouse (5)	3.40	(1.13)	5.71	(.61)	3.86	(.40)	2.00^a	(1.13)	3.99	(.71)
Daughter (26)	3.66	(.61)	5.07	(.76)	4.41	(1.00)	4.96^a	(1.01)	4.12	(.56)
Son (26)	3.41	(.70)	4.69	(1.09)	4.17	(1.35)	4.64^a	(1.15)	3.85	(.57)
Daughter-in-law (23)	3.32	(1.00)	4.58	(1.54)	4.43	(1.51)	4.80^a	(1.03)	3.95	(.95)
Other families (13)	3.54	(.61)	4.30	(1.52)	3.96	(1.22)	4.43^a	(1.09)	3.73	(.64)
Overall	3.47	(.77)	4.74	(1.20)	4.28	(1.25)	4.70	(1.12)	4.13	(.66)

*$p < .01$, ^{a}Differences among relationships tested by scheffe test (< .05)

Table 4. Item scores for FPCR subscales

Family Perception of Caregiving Role	M	(SD)
Conflicts with staff		
1. I feel like I have to be careful about how I make suggestions or requests about my relative's care or staff will think I am interfering.	3.36	(1.74)
2. I feel like an outsider in the care of my relative.	3.04	(1.93)
7. I feel that I have control over the care my relative receives.	3.16	(1.80)
10. Staff listen to my directions for my relative's care, but ignore them if they choose.	3.03	(1.68)
11. It is clear that staff have the real say about what care will be provided and how.	4.99	(1.75)
5. Things that I see as important in my relative's care staff often see as trivial or inconvenient.	2.68	(1.57)
16. Staff are most concerned about rules, routines and efficiency while I am most concerned about caring for my relative as an individual.	4.13	(1.79)
19. No major changes are made in the care of my relative without my approval.	3.44	(1.83)
41. When family and staff have different ideas about care the disagreements are negotiated and resolved.	3.03	(1.90)
54. Inability to control how your loved one is cared for.	3.88	(1.85)
Captivity		
23. I feel stressed between trying to give to my loved one with dementia as well as to other family responsibilities, job, etc.	4.47	(1.85)
34. I feel that my health has suffered because of my involvement in care.	3.05	(1.98)
49. Loss of contact with other people.	4.35	(1.79)
56. Wish you were free to lead a life of your own.	4.36	(1.80)
57. Feel trapped by your relative's illness.	4.10	(2.03)
59. Wish you had more time to spend with friends.	3.73	(1.83)
60. Wish you could get out of your role as caregiver.	3.74	(1.92)
61. Feel like you have lost your relative but still have the same role responsibilities as if you hadn't.	5.91	(1.58)
Guilt		
25. I feel guilty about my interactions with my loved one who is ill.	4.93	(1.83)
26. I feel that I don't do as much for my loved one in the facility as I could or should.	4.80	(1.57)
28. I feel that in the past, I haven't done as much for my loved one who is now in the facility as I could or should.	4.69	(1.86)
29. I feel nervous or depressed about my interactions with my loved one in the facility.	5.46	(1.46)
33. I feel comfortable in my interactions with my loved one.	4.11	(1.79)
Loss		
46. Having someone who really knew you well.	4.76	(1.74)
47. The practical things he/she used to do for you.	4.39	(1.98)
48. A chance to do some of the things you planned.	4.53	(1.81)
50. Loss of companionship.	5.24	(1.76)
51. Other's inability to know how your loved one used to be.	5.16	(1.50)
53. Lack of privacy with your loved one.	5.31	(1.54)
55. Loss of your role as primary caregiver of your loved one.	3.93	(1.78)

of caregiving) (M =4.28) and Conflict (with staff over caregiving) subscales (M =3.47) (Table 3).

The scores for Total FPCR and its subscales by relationship are summarizes in Table 3. There was a significant difference for the Guilt subscale by relationship ($p<.01$) with daughters scoring highest and spouses scoring lowest. Daughters reported the highest mean scores on the Total FPCR (M =4.12) and on the Conflicts (M = 3.66) and Guilt subscales (M =4.96). Spouses reported the highest mean scores on the Loss subscale (M =5.71), while daughters-in-law had the highest mean scores on the Captivity subscale (M =4.43).

Examination of individual item means revealed that family caregivers were most stressed from: 1) staff members' control on caregiving (M =4.99), 2) feeling the same responsibilities after placement (M =5.91), 3) guilt over their interaction with patients (M =5.46), 4) lack of privacy with patients (M =5.31).

Mean scores of each item in the subscales are described in Table 4.

DISCUSSION

1. Demographic characteristics and institutionalization

Most family caregivers were daughters, sons, and daughters-in-law, and compared with other studies that have been done with Korean family caregivers who take care of their elders with dementia at home (Choi, 1999; Youn, 1998), the percentage of sons in this study was considerably higher and that of daughters-in-law was lower. Over 85% of family caregivers had full time job in this study and this number was also higher than that found in other studies with family caregivers in the community by Son (1998) (28.2%), and Lee (1999) (41.7 %). Another notable finding was that a relatively higher percentage of female caregivers, especially daughters-in-law, in this study had full time jobs. These patterns were similar to those found by other studies that have been done to compare the stress of family caregivers who placed their elders in the facilities (Lee, Kim, &You, 1997; Song, 2000). In this study, only 50% of Korean caregivers reported they had shared a household with their elders with dementia.

Women's participation in occupational and social activities is increasing dramatically in Korea, and as females enter the work force, they become less available to be caregivers. There are also changes in living arrangements as increasing numbers of elderly people are living independently (Korea Institute for Health and Social Affairs, 1998). These demographic shifts may be factors in the increased placement of family members in long-term care facilities. All family caregivers who participated in the study reported they did not get any community-based services such as home care, day care, or short-term care. Although the community services are beginning to receive government encouragement and limited funding, these tend to be rather isolated demonstration projects in Korea (Yoon & Cha, 1999).

2. Family caregiver's satisfaction with care

Korean family caregivers were least satisfied with management effectiveness regarding staffing ratios and the facilities' resources. The fact that nursing staff assigned to patients, were insufficient and the sizes of the dementia care units in this study were considerably big, may be associated with this finding. This is also consistent with findings from other studies. Maas et al (2000) analyzed US family caregivers' interview data in the Family Involvement in Care intervention study and reported that family caregivers felt dissatisfaction with limited staff time and care resources. Tonatore (1998) studied predictors of family caregiver burden and satisfaction after nursing home placement and reported the similar results that nursing home resources and facilities' characteristics were more related to family caregivers' satisfaction and burden than patients' characteristics. In addition, family caregivers visited frequently or had their residents stayed longer in the facility, reported lower satisfaction with care provided by the facilities. These findings suggest that family caregivers noticed negative aspects of care and had difficulties to adapt to those aspects in the facilities over the post-placement phases.

Although having more staff does not guarantee better care, adequate staffing is an important determinant for quality of dementia care in long-term care facilities in Korea. In addition to the ratio of staff to patients, consideration must also be given to the quality of staff, and the ratio of professionals to paraprofessionals (nurses to nursing assistants), and the presence of other health professionals (physical therapist and activity therapist, etc).

The expectations and satisfaction with care can be modified by several factors and these included: the family member perceptions that staff members had limited time and care resources, the fact that family members had a history of difficulty with caregiving at home, and the fact that there was a perceived lack of resident care options in Korea. Family members perceive limited options, and accept the fact that they must be satisfied because they understand that they do not have any other alternatives. While family satisfaction with care could be one of the measures of a resident's quality of life as suggested by Montgomery (1994), this research highlights the multifaceted nature of this particular construct. Consequently, findings from this study suggests that family satisfaction may in fact be an acceptance of the lack of care options and not the genuine attitude of satisfaction with the care the resident is receiving. Thus, this would suggest that it is important when using family satisfaction with care as an indicator of resident quality of life, it should not be used as the sole proxy.

3. Family caregiver's stress from caregiving role

Korean family caregivers perceived moderate levels of conflict and reported the highest scores on the items stating "staff have real say about care," and "staff are more concerned about rules, routines and efficiency than about individual care." Duncan and Morgan's (1994) study exhibited similar findings. They found two major sources of conflicts between family caregivers and staff members in their study with family caregivers who had their relatives in long-term care facilities. The first source of conflict was staff members' failure to recognize that family caregivers possess expertise that could make a vital contribution to the care of their relatives. The second source was staff members' rejection of family caregivers' expectations that staff provide both technically excellent and emotionally involved care, just as family caregivers once did at home.

Family caregivers in this study reported moderately high feelings of captivity. They showed considerably high scores on the item which states that they feel the same role responsibilities after placement. These findings are congruent with the findings from other studies that the family caregiving role does not stop at the institutions' door but continues in an altered and still stressful way (Stephens et al., 1991). In addition, family caregivers reported relatively high feelings of guilt about their past and present caregiving and interaction with patients. This can be understood in the Korean cultural context that emphasizes family care of the elders. The traditional value of filial piety that emphasizes the provision of personal care for one's parents seems to strongly discourage the family from accepting care services from non-family members. As in other countries, elders in Korea desire to continue living at home as long as possible and still want their children to take care of them when they are not in good health (Yoon & Cha, 1999). However, this traditional family care of elders is challenged by the dramatic increases in industrialization, urbanization and women's involvement in economic activities outside the home. The care setting in Korea is in transition, and family caregivers experience feelings of being in a dilemma with high levels of guilt over their decision to place their family members in a long-term care facility. Differences in family caregivers' stress were related to caregivers' relationships with patients. Spouses expressed the highest feelings of loss among other family caregivers. They had strong feelings of loss of their intimate relationships with their spouses and their previous lives due to their family members' declines in mental and physical function, and changed personality, etc. Sons and daughters-in-law showed relatively lower feelings of loss. Choi (1999) reported similar findings in her study of female family caregivers that compared Koreans in Korea, Korean Americans, and Caucasian Americans. The researcher found that wives reported the highest feelings of loss. Daughters-in-law reported higher feelings of captivity than other family caregivers. Other studies with Korean family caregivers reported higher captivity feelings among daughters-in-law (Lee, 1999), exhibiting similar findings from this study. One explanation for the finding is that Korean daughters-in-law did their caregiving out of filial obligation, rather than by choice or out of affection toward their ill parents-in-law (Kim, 1996). This may lead to less satisfactory caregiving experiences among Korean daughters-in-law. Korean daughters reported the highest feelings of guilt among all family members. They reported that they felt guilt and regret about their past and present interactions with the patients and with the caregiving role. In Korea, a married daughter is traditionally an outsider to her old family, and she has no obligation to care for her own parents (Kim, 1996). Even though this has changed somewhat, and daughters are now more involved in their families of origin, this tradition still has strong roots in Korea.

4. Limitations of the study

Sampling limitations exist in this study. This study is based on a non-random convenience sample of family caregivers. Family caregivers who agreed to participate in this study may have more positive attitudes toward care provided by the facility. This study was conducted mainly in the southern area of Korea. Findings may be different in other area. The generalizability of the findings to other populations is therefore limited.

CONCLUSION AND SUGGESTION

This study contributes to the understanding of Korean family members' perceptions of satisfaction and stress from caregiving and their care relationships with patients and staff after placement of elderly persons with dementia in the facilities. The findings in this study suggest a need to conduct future studies and to develop policy to help family members adjust and cope effectively with the transition in caregiving from one environment to another and to prepare staff members to provide quality care based on family and patient needs. Other studies on the service needs of Korean family caregivers (Youn, 1998; Lee, Kim, & You, 1997) report that an absolute majority of Korean family caregivers need formal services and government support. The fundamental solution of the problem of dementia caregiving cannot be undertaken by individuals or families. In addition, there is a need for more studies to identify background and contextual variables which have a significant impact on family caregivers' stress and satisfaction after placement. These finding can serve as mechanisms for identifying vulnerable families and for focusing intervention strategies on those who need them.

As reported in this study, the existing units and facilities for dementia care in Korea vary in their institutional policies, physical design, staffing, programs, and treatment practices. To ensure that the unique needs of patients with dementia are met, there is a need to explore the quality of care according to the characteristics of facilities. It is also imperative that standards for dementia care unit be developed. Formalized standards and regulations will provide support and direction for staff working in this area. Minimum educational requirements including preservice training and ongoing training should be included in the standards. It is also suggested that development of community services in Korea would prevent unnecessary or premature institutionalization and would be more appropriate for the Korean culture.

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