THE EFFECT OF HOMEMAKING SERVICES ON ESTABLISHED MEASURES OF
PERCEIVED WELL-BEING IN COMMUNITY-DWELLING ELDERLY.

AN EXPLORATORY DESCRIPTIVE STUDY

by

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ABSTRACT

This exploratory study examines the effects of homemaking services on established measures of perceived well-being in community-dwelling seniors who have been assessed by Case Managers as qualifying for homemaking services. A hypothesis regarding the effects of homemaking on perceived well-being was developed and tested on an availability sample of elderly clients over 65 years of age who were cognitively competent. Face-to-face interviews using Reker and Wong's 1984 Revised Perceived Well-Being Scale were conducted on 28 subjects before homemaking was provided. Six homemaking visits later a follow-up interview using the same PWB scale and a qualitative questionnaire were conducted to investigate subjects' opinions of the homemaking service. It was anticipated the results might reflect the importance of emotional and social support factors as well as the physical support elements of homemaking services on the perceived well-being of subjects. Quantitative data was analyzed for changes in measures of perceived psychological, physical and general well-being of clients. Qualitative data was analyzed for themes associated with changes in well-being measures as a result of the service. Descriptive data reveal the average age, gender, culture, education, income, and chronic illness of the sample. Research suggests a strong correlation between perceived well-being and health status. If well-being and perceived client health are improved by homemaking services, there could be important implications for the distribution of health-care services for our elderly. Data may also suggest a range of options for Continuing Care and improved measures for evaluating the effectiveness of other health-care programs.
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And finally, I would like to thank all my elderly clients who shared so generously and enthusiastically their thoughts, feelings, and opinions. Your contribution to this research project made a difference.
DEDICATION

I dedicate this thesis to my cheering team: Dr. Jack Reilly, Ms. Kim Tappay and Mr. James Dougall.

To Jack, my husband, best friend, mentor and coach, who, for the past eight years, sacrificed his own dreams so I could realize mine. You were always there to encourage me when I faltered and catch me when I fell, and it was your strong faith in me that enabled me to continue to the end. I hope I can give you back some of your dreams.

To Kim, my daughter, best friend, and study partner. You were always there with an encouraging word and a hug, even when I wasn’t always there for you. I am so proud to see that my efforts have inspired you to be the best you can be. It was such a privilege to go to university together.

And to my father, Jim Dougall --- the best example of graceful aging I have ever known.

Thank you all for your unconditional love, encouragement, and support. You truly are the wind beneath my wings.
Chapter I
INTRODUCTION

My interest in the topic of this thesis is a result of my life-long fascination with aging. Along with my attraction to old people, I view the aging process with great intrigue. Later in my life this fascination led to my studies in psychology, gerontology, and social work, as well as considerable practical experience which I gained from working with old people. As a Case Manager for the Continuing Care Program in Richmond, I gained further knowledge of the increasing population of elderly clients for whom we provide services. Homemaking is one of the services which we, as Case Managers, assess community-dwelling elderly people as eligible to receive.

It is my own and many of my colleagues' opinions that when we assess elderly people for eligibility of homemaking services we frequently perceive an increased sense of emotional well-being in many of our clients. While we cannot attribute the apparent lift in mood solely to our presence, we feel there are positive aspects of our interactions and our offer of potential homemaking assistance which facilitate this 'lift' in affect. The idea that the mood of clients could be positively affected through interactions with Case Managers may be extended, and I became curious about the possibility of homemakers eliciting similar positive responses, and affecting client well-being. Because researchers (Kozma et al., 1991; Larson, 1978; Milsum, 1984; Matthews and Wakefield, 1984; Lee and Ishii-Kuntz, 1988; Chappell and Badger, 1989; Berkman and Syme, 1984; suggest strong correlations between well-being, health status, and delayed institutionalization, as a result of social support, the implications for this intervention of homemaking may have more significance than we realize.

As I reviewed the literature, I wondered if it was the emotional and social support that clients receive from their homemakers which contributes to their sense of well-being more so than the instrumental support of housecleaning. This was my bias as I entered the investigation. I was curious to learn whether the service we were providing was appropriate
to client need. Are vacuuming the rugs and doing the laundry as important as the social and emotional support many homemakers are known to provide (Matthews and Wakefield, 1992; Revicki and Mitchell, 1990; Larson, 1978)?

Because client perceived well-being and homemaking services provided by Richmond's Continuing Care Program had not been evaluated, and because clients have limited input into the services provided them, this study sought to gain understanding about homemaking service and client well-being by investigating the question: Do homemaking services affect the perceived well-being of community-dwelling seniors who suffer from chronic health conditions?

This study investigates the effect of the intervention by homemaking services on measures of perceived well-being of elderly people whom the Continuing Care Program has assessed as eligible for such service. Continuing Care is interested in improving services to clients and working conditions for Case Managers while at the same time maintaining fiscal accountability.

However, the primary objective of this study is to measure chronically ill clients' perceived well-being before and after the intervention of homemaking; how the latter affects their sense of well-being, and to explore their opinions and feelings about their homemakers and the service. The premise is that these elderly clients are the experts in living with chronic conditions and, as a result, can offer, through the descriptions of their own experience, reliable information about how chronic conditions affect them, what their requirements from homemaking services are, and what it is that contributes to their perceptions of well-being. Because one of the responsibilities of a social worker is to advocate for clients, it is also my intention with this study to encourage and stimulate more elder 'voice' in the services we provide rather than simply allowing them to be the passive recipients of our program. This study is an exploratory, descriptive study.

In order to collect and analyze the appropriate data for this research, the quantitative Revised Perceived Well-Being Scale (PWB), (Reker and Wong, 1984) was used to measure perceived psychological, physiological, and general well-being of 28 elderly subjects before and after homemaking services were introduced. Feelings and opinions about the
homemaking service were explored by asking open-ended questions in a posttest qualitative interview.

The biopsychosocial model of health serves as the theoretical foundation for this study. This perspective implies that health and illness are caused by multiple factors and produce multiple effects, and that the mind/body clearly influence a person's state of health (Kleinman, 1980; Chopra, 1993).

This study will attempt to link the concepts perceived well-being, perceived health, and social support, (homemaking service). If this study contributes to other research which suggests formal caregiving services, like homemaking, contribute to perceived well-being, and to improvements in subjective health status as a result, there may be important implications for the delivery of health services to the large numbers of chronically ill aged people who will require such care in Canada.

Chapter II will discuss some of the salient research findings in the areas of well-being, social support and the elderly.
Chapter II

LITERATURE REVIEW

Changes in rates of birth, mortality, and immigration have brought about an increase in the aging of our population (McDaniel, 1986; Chappell, 1990; McPherson, 1990). Birth rate refers to the birth of new individuals in our society, or the number of children born per 1000 women of child-bearing age (Havens, 1981). Women are having fewer babies today for a number of reasons: contraception, economics, and changing values and attitudes about family (Eichler, 1988; McDaniel, 1986; McPherson, 1990).

Although mortality typically refers to the loss of life, in the context of our aging population, demographers talk about increased life expectancy whenever they refer to the term mortality. For example, in the early 1900's the average individual lived to be about 48 years of age, whereas today we are living well into our mid 70's (McDaniel, 1986). More specifically, Canadian men have a life expectancy at birth of 70.2 years and women, 77.5 years (Statistics Canada, 1985). According to Havens (1981), this increase in life expectancy is the result of social, economic, and medical progress.

Immigration refers to the movement of persons in and/or out of our society, and today immigrants are older (McPherson, 1990). According to Gutman (1982), the median age of immigrants entering Canada has increased, as opposed to earlier in the century when immigrants were primarily young males; therefore these older immigrants contribute to the increase in the aging segment of the population.

This large proportion of the elderly in Canadian, and indeed, North American and other developing societies, is an intriguing and challenging phenomenon. In 1901, only 14.6% of the aged (65 and over) were over 80 years of age. These 80 year olds represented 0.7% of the total population of Canada (Statistics Canada, 1985). However, demographers project that by the year 2001, those over the age of 80 will comprise approximately 24.5% of the aged population, and will represent 3.3% of our total population in Canada (Health and Welfare Canada, 1990). Other researchers like Chappell (1990) and McPherson (1990)
suggest that by 2031, 45% of old people in Canada will be 75 years of age or older. This means that almost one half of seniors in Canada will be 'old'. The 1991 Census for Statistics Canada reports 12.9% of the population of British Columbia are 65+; this makes up 13.3% of the population aged 65+ in Canada (Statistics Canada, 1992). Table 1 illustrates the most current projections for age structure of the British Columbia population of those aged 65 and over for the years 1991, 2001, and 2011.

Of particular interest to the present study is the age distribution of Richmond residents. This distribution has changed dramatically since 1966. Richmond's population

Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>1991 % of Population Aged 65+</th>
<th>2001 % of Population Aged 65+</th>
<th>2011 % of Population Aged 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>32.9</td>
<td>27.5</td>
<td>30.2</td>
</tr>
<tr>
<td>70-74</td>
<td>26.4</td>
<td>25.0</td>
<td>23.0</td>
</tr>
<tr>
<td>75-79</td>
<td>20.1</td>
<td>20.9</td>
<td>18.2</td>
</tr>
<tr>
<td>80-84</td>
<td>20.1</td>
<td>14.4</td>
<td>14.1</td>
</tr>
<tr>
<td>85-89</td>
<td>5.8</td>
<td>8.2</td>
<td>9.0</td>
</tr>
<tr>
<td>90+</td>
<td>3.0</td>
<td>4.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source:

shows a general aging trend which is expected to continue as a result of the aging of the baby boom generation of the 50's. The majority of the Richmond population currently falls into the 30 to 40 age group. However, there is a growing number of middle-aged adults in the 45 to 64 range, as well as a substantial increase in the proportion of seniors aged 65 and older. The number of school aged children has remained stable since 1981, but the
proportion of young people aged 5 to 19 has decreased dramatically since 1966, as a proportion of the total population (City of Richmond Economic Development Office Pamphlet Jan. 1992).

The aging of the Richmond population is reflected in the median age, which was 34.3 years in 1986. The median age is expected to reach 40 years by 2004. This means that 50% of the population of Richmond will be over 40. While the population of the Lower Mainland is also aging, the median age is not expected to reach 40 until 2011. In 1986, Richmond residents over 65 years of age represented 9% of the total Richmond population. They are expected to make up to 13% of the population by 1996, and 16% by 2006. Those over the age of 80 are expected to make up 2.67% of the total projected population of Richmond in 2006 of 159,600 (City of Richmond Economic Development Office Pamphlet Jan. 1992).

In one sense, according to Butler et al. (1991), “this ‘demographic revolution’ should be seen as a triumph of survivorship rather than as a cause for despair” (p.8). However, we cannot deny that the number of aged in the population affects society. Researchers, policy makers, health professionals, and gerontologists are concerned about the impact of increasing numbers of elderly on income maintenance and particularly on the cost of health care to support such a burgeoning older population (Butler et al., 1991).

It seems pertinent to clarify the term “old” for purposes of this study. How old is old? The selection of 65 years of age is a peremptory one. As a consequence of social legislation in the late 19th and early 20th centuries, sixty-five has become the demarcation between ‘middle’ and ‘old’ age (Guest, 1985). This ‘traditional age’ has been maintained over the years for social purposes: a means of determining eligibility for various old age pensions and suggested times for retirement from the work place (Guest, 1985). The age of 65, however, has more limited relevance in describing concepts such as well-being, health, creativity, endurance and so on. The concept of “old” seems vague in many ways, and more recently, gerontologists have attempted to deal with this concept by dividing old age into three groups: the young old, middle old, and the old old: 65 to 75, 75 to 85, and 85+ (Neugarten, 1974). The point is, that age can be a convenient but imprecise indicator of the
physical and mental status of a person, but a rather poor indicator of itself and perhaps it
should not be so heavily relied upon for information about human beings.

Many elderly people, however, would not argue that growing old can often be
difficult (Rodgers et al., 1988). Though poor health is not necessarily associated with
aging, compared to younger people, the elderly suffer a greater share of chronic conditions
and psychosocial distress (Revicki and Mitchell, 1990). According to Atchley (1989),
serious chronic illnesses such as arthritis, high blood pressure, and heart disease, tend to
increase after fifty years of age. Although the greater majority of older people do not suffer
seriously impairing chronic conditions, 7 out of 8 report having one or more chronic
condition, 4 in 10 experience restrictions on their ability to perform such activities as
personal care, and almost 1 in 10 is bedridden and housebound (Rice, 1985). Havens
(1981) suggests that: “25 percent of the total Canadian population will require long-term
care sometime during their life” (p.27). She continues in her article Population Projections:
Certainties and Uncertainties that “on average six percent of the population aged 65 and
over, at any given time in Canada reside in a long-term care facility” (p.27), while Nett
(1984) suggests that “one in five Canadians will spend time in some type of long-term care
facility” (p.5 in Family Ties and Aging, 1989).

However, despite functional declines in some physiological capacities, what is
significant is not that these gradual declines occur, but rather that the majority of older
individuals adapt amazingly well to these changes. Comfort (1990) suggests that
approximately 86 percent of people over 65 remain in their homes and communities and
demonstrate adequate coping behaviour in meeting the challenges of everyday life.

While this researcher acknowledges the fact that many elderly live their lives
independently despite possible declines in functional ability due to chronic illness, there
still are many who need support (in addition to aid from family and friends), because the
severity of their disability precludes self-sufficiency. In fact, a study by Forbes et al. (1987)
reports that about 12 percent of community-dwelling elderly over 65 years of age need
some assistance with activities of daily living, and approximately 25 percent require help
with shopping and housework. Formal caregiving agencies are frequently called upon to
assist older people maintain as much of their independence in their homes and the community as possible by performing tasks such as house cleaning, personal assistance, shopping and so on.

By employing the services of third party commercial homemaking agencies, the Continuing Care Program in British Columbia strives to provide such assistance. Our elderly population is of great importance to the Continuing Care Division (CCD) of the Richmond Health Department. The Division’s philosophy states:

The Continuing Care Division (CCD) is committed to promoting the well-being, dignity, and independence of clients and their families.

CCD strives to promote the well-being, dignity, and independence of 1,320 clients through the provision of 15,969 hours of service per month. Appendix J illustrates homemaking statistics for Richmond, Lower Mainland, effective February 1993. Theoretically, this mandate has been satisfied; however, in practice, the concept of ‘well-being’ and its relationship to the intervention of formal support has not been investigated.

As previously suggested, a proportion of the older population may become chronically ill and disabled, and in the past, when there were fewer elderly in the population, we often institutionalized our old people when they could no longer live independently (Pallan and Young, 1992). However, with the projected growth rates for those over 65 in Canada, of 30 to 52 percent by the year 2000, and with the increase in life expectancy at birth, (70.2 years for males and 77.5 years for females) we are forced to consider alternatives to institutionalization because of the cost of such care (Havens, 1981; Government of Canada, 1983).

There has been considerable evidence to support the advantages of enabling older individuals to remain in their homes. According to Forbes et al., (1987), elderly people much prefer this alternative to institutional care. In fact, this was a stated goal of the Canadian Medical Association in a report of a study in 1983/84 on our health-care system. The task force investigated and acknowledged the impact our aging population would have on future demands for health services and concluded that we need to move away from institutional solutions toward “a new program of care . . . which emphasizes
independent and productive living at home." (Rachlis and Kushner, 1989, p.41). Studies also report an increased sense of well-being in those individuals who are not institutionalized (Blazer, 1982; Cobb, 1979; Crandall, 1980; Williams, 1989). Kozma (1991) and Larson (1978) report a strong correlation between well-being, health status, and delayed institutionalization; that is, psychological and social health is associated with subjective physical health.

In spite of the above general findings, there is a paucity of research which explores the relationship between homemaking services and perceived well-being in the elderly. Brothers and Mullaney (1980), two students of social work at the University of British Columbia (UBC), conducted a survey of 90 clients of the Richmond Long Term Care home support. The survey concentrated on feelings of satisfaction/dissatisfaction of the recipients and families of the program, and revealed that 92% of clients were satisfied with the homemaking service.

In 1982, Stark et al. investigated long term care data by level of care, and assessment process. The study revealed that inter-rater reliability was high when assessment levels by different assessors were compared. In other words, assessors were consistent in their assessment of client care levels (Stark et al., 1982). Other researchers have investigated the degree of satisfaction clients express about homemakers by employing qualitative techniques (Fashimpar and Grinell, 1978; Eustis and Fischer, 1991; Barer, 1992) while some have explored the concept of well-being in the elderly by employing established quantitative measures (Lawton, 1972; Lawton, Kleban and diCarlo, 1984; Reker and Wong, 1984). Bowling and Browne, (1987) investigated the emotional well-being and social networks of 620 elderly in London, England and found that although associations were found between social network variables and provision of informal help, health status explained more of the variation in emotional well-being of subjects.

Findings from a longitudinal study of approximately 2000 elderly by Krause (1990) report that formal support reduces the harmful effects of perceived health problems. A conflicting study by Weissert et al., (1988) however, implied that home care does not produce a marked improvement in health status of the elderly, nor does it delay
institutionalization. "What it does produce is an improved degree of satisfaction and contentment among the elderly" (p.368). This seems an ironic contradiction. It could be argued that improved degree of satisfaction and contentment produces improvements in perceived health, and therefore well-being, although I am sure this is not always the case.

A more recent study by Matthews and Wakefield (1992) of the Gerontology Research Centre at the University of Guelph in Ontario, examined characteristics of homemakers and aspects of satisfaction between 137 homemakers and 155 clients over a two year period. Findings revealed an overall client satisfaction with homemaking service, and a slight improvement in overall health status (Matthews and Wakefield, 1992).

There are many studies which do not examine home care service and client feelings but rather the cost effectiveness of home care programs (Weiler, 1974). When Herdman and Kerr (1975) and Walton and McNaim (1978) conducted cost benefit analyses of home care, they discovered when analyzing the data that not only was home care found to be cost effective, it was also beneficial to clients in terms of continuity of independence, and improved health status.

Because of the disabilities caused by chronic conditions, a small portion of our elderly population is often forced to seek the help of formal supports such as homemaking in order to continue to live in the community as normally as possible (Sutherland and Fulton, 1988). Chronic illnesses affect and are affected by perceived well-being of elderly people (Barrett, 1972; Callahan, 1990). Perceptions of well-being are also associated with social support (formal and informal), which is believed to serve as a buffer against adverse health effects of stressful events throughout life (Burdman, 1986; Callahan, 1990). Much of the research on well-being and social support focuses on populations of average age, while many studies investigating our elderly tend to explore perceived well-being and formal support separately (Krause, 1990; Eustis and Fisher, 1991; Barer, 1992; Lawton et al., 1984; Bowling and Browne, 1987; Blanford and Chapell, 1990). Researchers such as Kozma et al. (1991) investigated correlates of well-being in the aged; Matthews and Wakefield (1992) examined sources of satisfaction in the relationships between elderly and formal and informal support, and Brearley (1977) discusses well-being of
institutionalized elderly. Unfortunately, there are few, if any, studies in British Columbia which have actually investigated the effect of formal support services, namely homemaking, on perceptions of well-being.

In this chapter, a review of some of the most salient studies of perceived well-being in the elderly as they relate to this author's research will be acknowledged. Further, the next few paragraphs will briefly discuss chronic illness because often it is the chronic illnesses and conditions of older people that often cause them to seek out formal support (i.e. homemaking, Meals-On-Wheels, volunteer shoppers). Chronic conditions frequently create a decreased mobility and flexibility which prevents individuals from performing those tasks which otherwise might have been performed without problems before the individual was affected. For example, conditions of the joint, heart, respiratory system, or terminal disease (Kart et al., 1992).

In essence chronic illness is THE challenge of this era to hospitals and public health officials, and to the medical, nursing, and other professions concerned with sickness, disability . . . [It is] America's No. 1 health problem . . . (In Chronic Illness and the Quality of Life, p.1)

The above words of L. Mayo, then chairman of the Commission on Chronic Illness, were spoken at a conference on chronic illness in 1956 (Strauss and Glaser, 1975). The Commission had just completed a report on chronic illness. Most health professionals agree that the definition used in that report still holds today:

All impairments or deviations from normal which have one or more of the following characteristics: are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the patient for rehabilitation, may be expected to require a long period of supervision, observation, or care. (In Chronic Illness and the Quality of Life, p.1).

This author will adopt this definition for purposes of this study.

Although many elderly die today as a result of heart disease, malignant neoplasms, and cerebro-vascular diseases, it is the chronic diseases that last (Fillenbaum, 1984). The prevalence of chronic disease among the elderly is higher than among younger persons (Kart et al., 1992). For example, the reported prevalence rates among the elderly for heart
conditions, hypertension, arthritis, diabetes, visual and hearing impairments and urinary diseases show the most substantial differences when compared with the prevalence rates of these chronic conditions among the younger population (Kart et al., 1992). Approximately 21.2% of elderly respondents to a National Health Survey questionnaire in 1984 reported having two or more of the following illnesses: cardiovascular disease, arthritis, osteoporosis, stroke, cancer, respiratory disease, and dementia (Alzheimer’s). Chronic conditions are long lasting, and their irreversible pathology is causes their slow steady progression (Kart 1990).

Gilford (1988) reports “most health survey data show a pattern in which vigorous old age predominates, but where there is a clear association of advancing age with poorer functioning” (p.33). Harris (1978) estimated that 45.4% of American aged with chronic conditions suffer some form of restriction on their activities because of their condition, and Chappell (1990) suggests that less than half (38.1%) of seniors in Canada suffer from some form of limitation in their functioning as a result of chronic conditions.

The good news is that function can be maintained well into old age, and Manton (1989) claims that elderly vary in the rate at which functional losses occur. It is important to keep in mind that the elderly are experts at adapting to conditions associated with aging. As previously suggested, the great majority of elderly live in the community, are cognitively intact and independent in their activities of daily living (ADL), despite the fact that they have had or are currently experiencing a chronic condition. However, there are certain conditions which cause such irreversible damage and decreased function and mobility that a small percentage of old people are forced to appeal to those from formal and informal support groups for help which will enable them to stay in the community in their homes. This form of social support is known to affect the well-being of those receiving it (Larson, 1978; Cassel, 1974; Callahan, 1990).
THE CONCEPTS OF SOCIAL SUPPORT AND WELL-BEING

Social Support

The motive behind this writer's investigation was curiosity about a service we offer to elderly people: homemaking services. I wondered whether the intervention of homemaking had an effect on the perceived well-being of chronically ill community dwelling seniors who were assessed by Case Managers to receive such service. One might assume such services positively affect clients if we (society) are offering the service. Although Continuing Care strives to promote and enhance the well-being of clients, and the mandate is satisfied theoretically, in Richmond, the effect of homemaking services on client well-being has not been evaluated. Researchers have examined other aspects of client/formal support relationships but to the best of this writer's knowledge, the concept of well-being and homemaking have not yet been thoroughly investigated, and this study may, in part, serve to address this gap. Research shows a strong correlation between social support (formal and informal), perceived well-being of elderly people, and perceived health status (Blazer, 1982). This fact provides the thrust of the writer's investigation.

It is not only social support but also the quality and quantity of such support that is recognized as important determinants of well-being, health and even mortality (Fillenbaum, 1984; Cassel, 1974). This connection is especially strong for the elderly because of the high prevalence of dependency among them. Without the proper social support loneliness can be a pervasive influence in the lives of elderly sick people.

Loneliness means different things to different people, but for the elderly it can be defined as a wish for contact with other people which cannot be achieved. It is an unpleasant disposition, related to unhappiness, which may be experienced in the communal situation as well as in isolation (Dychtwald, 1990). Old people are eight times more likely to live alone than are people under 65, but very old people are rather less likely to be on their own than the newly retired (Tunstall, 1966). Tunstall (1966) found a link between loneliness and isolation: those who are more isolated in the sense of having fewer contacts
are more likely to say they are lonely. Kart (1990) suggests that loneliness may be counteracted through social contact from either formal or informal caregivers.

More recent research found that social activity with friends was more important in reducing loneliness and improving morale in elderly than interactions with neighbors. Interactions with family (informal support) were found to be unrelated to well-being (Lee and Ishii-Kuntz, 1988). This rather disconcerting finding may be explained by data from an earlier study. Larson et al. (1986) found that the influence of friends and family is a function of the time-frame used in a study. Over a short period, feelings of immediate well-being were found to be influenced more favourably by time spent with friends than by time spent with family; however, over the long term, it appears that the family contacts provide more stable sources of physical and emotional support than friends.

Disability due to chronic health conditions, poverty, and widowhood contributes to the sense of loneliness older people may experience. The most striking effect of morbidity in the aged, as compared with younger adults, is the resulting chronic disability (Woodruff-Pak, 1988). Adults over the age of 65 in 1980 experienced 50 percent more restricted activity days per year than adults age 45 to 64 (Flaherty, 1987). Homemakers, as formal caregivers, assist disabled elderly people in many ways, but it is the reports of the usefulness of the emotional and social support given to clients by homemakers that is of significant importance (Burdman, 1986).

Social support is thought to serve as protection against adverse health effects of loneliness and stressful events throughout life (Krause, 1990; Cassel, 1974; Callahan, 1990). It facilitates adaptation to changes and crises, and since the elderly experience a greater number of stressful events and losses than any other age group (grieving the death of a spouse, widowhood, loss of friends, illness, retirement, decreased income), the existence of social supports could clearly influence their quality of life (Kane and Kane, 1981).

Cobb (1979) suggests depression is less frequent in the presence of social support; adaptation following bereavement is improved by the availability or provision of social support; recovery from various diseases (cardiac failure, tuberculosis, psychosomatic illness, and psychiatric illness) is accelerated or facilitated by high levels of social support.
Social support from family members can decrease the risk of institutionalization of dependent elderly relatives, according to Shanas (1979). Data from the 1975 National Survey of Non-Institutionalized Community Elderly show that an elderly person’s spouse and a child living in the household are the major sources of help to the elderly during illness (Shanas, 1979). Chappell and Badger (1989), however, found that being childless was not related to well-being or life satisfaction, indicating that those who are isolated (not having children) need not necessarily experience lower psychological well-being. People may have many children and friends yet feel isolated. Conversely a person may have few friends and not feel emotional loss or isolation.

Findings from two longitudinal studies that assessed risk factors leading to institutionalization among the elderly also show the protective effects of social support. Vincente et al. (1979) report that married persons are least likely to go into a long-term care facility before they die. Findings suggest that the effect of marital status, however, is indirect (Larson, 1978). This may be because the primary effect of marital status falls on other predictors of perceived well-being such as social activity. It is often the friends and socializing that marriage brings that can predict well-being as opposed to the relationship itself, or, perhaps the fact that you have someone to look after you so you are not institutionalized.

Some researchers have questioned the assumption that social support is a unidimensional entity (Blazer, 1982; Hogue and Gorton, 1981). Blazer (1982) proposed a three-parameter model of social support. Its components include: 1) roles and available role attachments, 2) perceived social support, and 3) frequency of social interaction. Hogue and Gorton (1981) differentiate social support from social network, stating that social network is the quantitative characteristic of an individual’s social and community ties, whereas social support is the psychological characteristic of an individual’s social network. Both of these studies separate the subjective and the objective aspects of social support, and both suggest that the subjective part is the key health promotive factor. Blazer (1982) hypothesized that social support may influence health in a variety of ways but always through the mechanism of the perception of social support.
As mentioned previously, Krause (1990), Cassel (1974) and Callahan (1990) report that social support serves as protection against adverse health effects of stressful events through life, and the elderly are a group of people who experience stressful events in their lives, probably more so than other people in younger age groups (Crandall, 1980). Social support, therefore, is believed to facilitate adaptation to the crises and changes which occur during this period in life.

Kasl and Berkman (1981) linked social support to mortality in adults. Evaluation of the Alameda County sample of adults showed significantly fewer early deaths among people with large social networks. This inverse relationship between social network and mortality held even when controlling for health status, and health practices known to increase mortality: smoking, overeating, alcohol consumption, and lack of physical activity. Unfortunately, these studies lack comparative information regarding the role of social support in different populations like widowed people, groups from different cultures, and elderly with varying health care needs.

According to Revicki and Mitchell (1990), elderly people who receive what they refer to as "instrumental" social support: help with homemaking and household maintenance, tend to have less emotional distress and psychosomatic complaints.

Social support studies of the elderly show two things: they exemplify the beneficial aspects of social support in terms of lower mortality, decreased institutionalization, and higher morale (Lawton, 1972), and they support the theories of the multidimensional nature of social support (Blazer, 1982).

**Well-Being**

Perceived *well-being* is a term that seems to be implicitly understood by all who use the term, but all too often, vague inconsistent definitions inundate the literature. Perceived well-being subsumes several constructs such as affect (Bradburn, 1969), happiness (Wilson, 1967), adjustment (Graney and Graney, 1973), morale (Lawton, 1972), satisfaction (Neugarten, et al., 1961), but these terms do not appear as a well-articulated conceptual
system for understanding certain life or quality-of-life issues. Instead, this author like Kozma et al. (1991) found the literature to be "full of terminological inconsistencies and construct overlap" (p.3). As well, I felt vindicated when I read a recent document by the Institute of Health Promotion and Research at UBC, which evaluated measurements of well-being. In this report, Dr. Carol Herbert and Dr. John Milsum (1990) claim: "Several problems were confirmed by the literature review, which we had previously suspected. Both the literature and our consultations with the Advisory Team and other experts make it clear that no explicit definition of 'well-being' exists" (p.56). According to Kozma et al. (1991), one factor which contributes to this inconsistent terminology is that construct meanings adopted by researchers reflect their differences in philosophical, conceptual and methodological procedures.

Defining 'well-being' was a difficult task, because it means so many things to so many people, particularly researchers. Well-being encompasses a gamut of terms which include: morale, satisfaction, happiness, affect, adjustment, mental health, mood and physiological and subjective well-being, and, as has been strongly suggested, no researcher has ever really defined the term satisfactorily. The author felt it would be appropriate to identify these more common terms in the dictionary in an attempt to gain a clearer understanding of what other researchers may consider for workable definitions of well-being. Following is a list of definitions taken from the Oxford Dictionary of Current English (1985):

- **Morale**
  mental attitude or bearing of person or group, as regards confidence
- **Satisfaction**
  fulfil expectations or desires, content, pleased, thing that satisfies desire or gratifies feeling, thing that settles obligation or debt
- **Happiness**
  feeling or show pleasure, or contentment; fortunate, pleasing
- **Affect**
  mental state, mood, feeling
- **Mental Health**
  mental soundness
- **Mood**
  state of mind or feeling
- **Well-being**
  welfare
- **Subjective**
  conscious or thinking or percipient subject as opposed to real or external
Reker and Wong (1984, p.24). who constructed the Perceived Well-Being Scale used in this study define psychological well-being as:

- the presence of positive emotions such as happiness, contentment, joy, and peace of mind and the absence of negative emotions such as fear, anxiety, and depression.

Physical well-being is defined as:

- self-rated physical health and vitality coupled with perceived absence of physical discomforts.

General well-being is defined as:

- the composite of psychological and physiological well-being.

Because the PWB Scale is used in this study, the above definitions of well-being have been adopted by this writer.

There is a multitude of well-being scales which measure anything from life satisfaction, to morale and agitation, to perceived physical and psychological well-being; however, for the purposes of this research this investigator has chosen to use a Canadian measurement especially devised for use with elderly subjects. The writer concurs with other research (Burdman, 1986; Callahan, 1990; Krause, 1990), and because of her own experiences, that perceived well-being is affected by social support, and that this subjective perception of well-being, in turn, affects both subjective and objective health as well as the psychological status of people. As mentioned earlier in this paper, there is a strong correlation between well-being and perceived health (Kozma et al., 1991). The importance of well-being has many implications for the delivery of health care in our country, particularly to our expanding elderly population.

Well-being is a relative term which probably varies with age, among other things (Barrett, 1972). The well-being of an individual is dependent upon the way he/she perceives his/her health, socioeconomic status, functional ability, housing arrangements, and the availability of services (Phillips and Gaylord, 1985). Well-being is also influenced by those life events that are frequently part of an aged person's life: widowhood, relocation, retirement (Harris, 1978). Past events and current events also impact on perceived well-
being. In many studies, both physical and psychosocial factors were found to predict longevity (Palmore, 1969; Wingard, 1982; Palmore and Stone 1973; Kasl and Berkman, 1981). As previously mentioned, social relations are known to affect well-being. The quality and numbers of social relations are recognized as very important determinants of well-being, health and mortality (Kozma et al., 1991). Perhaps it is the perception of companionship itself rather than the emotional or other types of support provided by it that is the important factor in the relationship.

According to Kozma et al. (1991), there has been little support for gender differences in perceived well-being and when gender differences have been found they tend to be small (Diener, 1984). Gender has been found to interact with such variables as health and income in their relationship to perceived well-being (Medley, 1976).

A very small positive relationship has been estimated in a review by Larson (1978) regarding age and well-being. Other studies found near zero correlations for both zero-order effects and first-order effects (Herzog and Rogers, 1981; Stock et al., 1983.). The aforementioned studies suggest that age has little direct effect on perceived well-being, but may have important interactive effects with other predictors such as race (Kozma et al., 1991).

The research on age and perceived well-being requires longitudinal data before an accurate assessment of their relationship is possible, according to Kozma (1991). Based upon the cross-sectional data available, young people appear to be as happy as older people. The age similarity suggests that a person's level of well-being remains stable over time until the early 70's (Rodgers et al., 1988).

According to Larson (1978), education has little influence on perceived well-being, rather it appears to be the lifestyle that an education can provide (higher income level, better housing, etc.) that influences the perceived well-being of elderly people.

Well-being and social support are important constructs which can influence the health and psychological state of an individual in many ways. The idea that the mind/body together may determine health and illness implies a biopsychosocial model for studying this issue, as opposed to the dominant model in medicine today: the biomedical
one. The biomedical model assumes that psychological and social processes are largely independent of the disease process (Kasl and Berkman, 1981).

As the name biopsychosocial implies, the fundamental assumption states that health or illness outcome is a consequence of the interplay of biological, psychological, and social factors (Kleinman, 1980; Chopra, 1993). As such, both macro-level processes such as the existence of social support or the presence of depression, and micro-level processes such as chemical imbalances and/or cellular disorders interact to produce either a state of health or a state of illness (Herbert and Milsum, 1990). The biopsychosocial model implies that health and illness are caused by multiple factors which produce multiple effects. The model further maintains that the mind and the body cannot be distinguished in matters of health and illness because both so clearly influence one’s state of health (Cousins, 1979). The biopsychosocial model emphasizes health and illness, rather than viewing illness as a deviation from a steady state. From this perspective, health becomes something one achieves through meeting biological, psychological, and social needs, instead of something that is taken for granted (Kleinman, 1980; Chopra, 1993).

Reviewing the literature points to the importance of social support as an essential component for sense of well-being. Previous studies have explored the importance of social support and well-being but studies to date have not supplied data about the effect of the formal support system, homemaking, on elderly client well-being. In this study the author hopes to further the study of the social support homemakers provide and the perceptions of client well-being, and thus contribute to the gap in the literature.

Perceived well-being will be measured before and after homemaking services to try to determine whether these services affect perceived well-being of clients; and recipients of service will be asked to share their opinions about the service. From this research we may be able to report a positive relationship between homemaker support and the perceived well-being of subjects. If changes occur as a result of the social support received from homemaking, Continuing Care will be able to consider the mandate satisfied in practice. This research may provide the impetus for further exploration and evaluation of other social health-care services by other social workers and others in the field.
Chapter III

CONCEPTUAL FRAMEWORK

Figure 1 depicts a conceptual model that was designed by this author to investigate associations between the chronic health problems of elderly respondents, formal support, perceived general well-being, and perceived health status of community-dwelling elderly who receive the intervention of homemaking services.

The biopsychosocial model of health has influenced this writer. This model maintains that health and illness are determined by physiological, psychological, and social factors, and multiple effects are produced as a result (Kleinman, 1980; Chopra, 1993). The interaction of these variables are addressed through the systems theory approach to health and illness (Herbert and Milsum, 1990). Systems theory holds that all levels of organization are linked to one another hierarchically, therefore a change in one level creates changes in all the other levels (Turner, 1986). This suggests that the micro level processes such as cellular pathology are intertwined within the macro level processes, such as societal values and beliefs; and that micro level changes can have significant macro level effects. Consequently, health, illness, and medical care are all seen as interrelated and interdependent processes which involve interacting changes within the individual and on these various levels (Milsum, 1984).

For the purposes of this conceptual framework there are two elements of existence: the self (Block A) and everything else - the environment that self experiences (Block B). In particular this study is interested in exploring the elements of this environment related to health (well-being).

Block A of the map depicts the individual; the self-concept. The self-concept according to Milsum (1984) “can be viewed as the current accumulation of our sense of self and our purpose” (p.35). Phenomenologists see the self as the “I” or the “Me”. Our self-concept is dynamic and receives information from many other processes. The self experiences combinations of physical, mental, social and spiritual health. These factors have been
Figure 1
Conceptual Model of Self Interacting with Environmental Factors

A
SELF
(Desired Well-Being)

C
Subjective Evaluation of Well-Being
(Perceived Well-Being)

D
HEALTH RESOURCES
Physical Mental Social

E
HEALTH DYNAMICS
Physical Mental Social

B
ENVIRONMENT
Positive Reinforcers
(Homemaking Services)
Negative Stressors
Positive Reinforcers
(Negative Stressors
(Chronic Illness)

FUNCTIONAL WELL-BEING
Coping Level

FEEDBACK
adopted for this conceptual framework from the theoretical base of the World Health Organization (1974) which recognizes health, in the broad definition, to be “total well-being”:

Health is a state of physical, mental, and social well-being, and not merely the absence of disease and infirmity. (WHO, 1974).

For purposes of this research, the writer will assume that the word “mental” in the above definition of health includes emotional, spiritual and psychological well-being.

In this conceptual model, the self will be viewed as an individual who exists in the state of chronic illness (respondents of this study) preceded by a ‘normal aging’ state. According to Atchley (1989), normal aging refers to the usual patterns of human aging; that is to say, a lack of mental or physical disability. Aging often slows people down, but does not always disable them. Although the conditions that elderly people face as a result of illness are very real and the adjustments they must make are complex, their ability to cope with the many difficulties are impressive. However, this study is not investigating “normal aging” but the concept is acknowledged, and writers such as Chopra (1993), Comfort (1990), Crandall (1980), Dychtwald (1990), and Kastenbaum (1964), contribute to the plethora of literature about normal aging processes.

Many feel the self-concept to be poorly understood. On one hand, people often have stable self-image and stable levels of self-esteem, but events like chronic illness in old age can produce drastic changes in self-concept and self-esteem. Many of these changes will be temporary, and some will be permanent.

Although many researchers measure global self-esteem, it is important to remember that the self-concept is a composite of self-evaluations. Block C - Subjective Evaluations of Well-Being, suggests we have the intellectual capability to evaluate how we’re doing in the many aspects of our lives. Some of these aspects are involved in the disease process and include body image, achievement, social functioning, and self-identification (Milsum, 1984).

Block D - Health Resources, is a component of health which refers to physical, mental and social resources that may either optimize or minimize well-being. For example,
our gene pool can either benefit or hinder our physical and psychological states. An example of social health resources might include number of friends and family size.

Block E depicts another component of health, Health Dynamics: physical, mental and social. For example, physical dynamics might include the opportunity for exercise or the ability to obtain adequate nutrition. Psychological dynamics might be affected by the level of education we receive and the consequences of such on the way we think of our health. Examples of social dynamics might include interactions with family and friends and participation in social activities and organizations.

Blocks D and E, Health Resources and Health Dynamics, are the components of health subjected to modifiers. The map displays two categories of conditioning factors or modifiers in the environment: positive ones will be called Reinforcers and negative ones are called Stressors. Examples of positive reinforcers which tend to impact upon Health Resources could include a large family, memberships in clubs and organizations, social support, access to medical care. Whether or not self capitalizes on these reinforcers depends on the dynamics.

Stressors, the negative modifiers, might include chronic conditions which result in poor health, economics, lack of family, no friends, widowhood. Resources and dynamics reflect back and forth between one another as do reinforcers and stressors. The arrows indicate interactions between factors.

The coping level leads to a state of Functional Well-Being (objective or subjective). Functional well-being feeds back, as do all the other elements within the environment of health-related factors, to the self and modifies the baseline subjective well-being. This cycle continues throughout life.

To summarize: Block A refers to the self who, with increasing years, experiences varying degrees of chronic illness and/or disability. The self may adopt successful coping strategies and function with the illness and disability or may experience negative outcomes as a result of physical and environmental stressors which may result in varying degrees of loneliness, depression, decreased independence and mobility, social isolation, and possibly early institutionalization. Both negative outcomes and successful coping strategies affect
the perceived well-being of the individual.

Well-being can be described, discussed, defined, conceptualized and evaluated as having subjective or objective components. The applied definition suggests that operational assessments of well-being usually resort to a description or measure of subject(s) functional capabilities and/or limitations. Established literature in many inter-related disciplines suggest intimate relationships between these two perspectives as well as between elements within each individual category: e.g. you are as young or old as you feel.

Perceived well-being is an accepted (at least previously used) subjective measure which may correlate with perceived health (another subjective) and just possibly might exert an effect on associated accepted objective measures of well-being (e.g. physical examination).

Perceived general well-being is a relative term which probably varies with age (among others). It may be affected by:

1. the existence of chronic physical illness
2. the availability and degree of support resources which may be:
   a. formal - provided by care agencies
   b. informal - provided by family and friends

This study is designed to explore the possible effect of the provision of formal support homemaking services on Reker and Wong's (1984) Perceived Well-Being Scale (PWB), and to investigate resulting implications on subjects' perceived health and changes in their state of chronic illness. A thorough review of the literature reveals there is a significant effect between formal and informal social support and perceived well-being. The measures of formal support used in this study reflect instrumental assistance by homemakers given specifically in response to the health problems and functional disability of elderly subjects. As is depicted in the model, formal and informal support in the form of reinforcers may affect a person's perceived well-being. Thus the thrust of this research: homemaking - does it act as a reinforcer and affect perceived well-being? The literature survey suggests strong correlations between social support systems, perceived well-
being, and subjective health status (Blazer 1982; Hogue and Gorton, 1981; Kozma et al., 1991; Cassel, 1974).

Perceived well-being is measured by an established scale - The Revised Perceived Well-Being Scale (Reker and Wong, 1984). Perceived well-being is divided into psychological well-being, and physical well-being; the sum of the two resulting in a general well-being measure. Well-being and social support are important constructs which are thought to influence the health and psychological state of people in many ways. Many studies suggest a strong correlation between perceived well-being and health status (McNeil and Harsany, 1989; Stoller, 1984; Reker and Wong, 1983, 1984; Cassel, 1974). If well-being does affect perceived health status of individuals positively, the model depicts a possible balance to the problems of loneliness, depression, decreased independence, social isolation, and early institutionalization. In turn, a reduction in these problems of aging may allow many elderly people to remain independently in their homes, and to participate actively in the community.
Chapter IV

METHODOLOGY

This study is an exploratory descriptive study, the objective of which is to:

1. measure perceived well-being of subjects before and after homemaking services.
2. determine whether homemaking services affect the perceived well-being of subjects.
3. determine subjects' feelings regarding their homemaker and the service.

Although this study employs primarily a quantitative methodology, an attempt is made to elucidate the data through the administration of 4 qualitative questions. The principle of triangulation may be used in data collection to balance each method's weaknesses and strengthen study design (Patton, 1990; Rubin and Babbie, 1989; Cozby, 1985). Subjects were interviewed using an established measure (PWB-Revised Scale) (Reker and Wong, 1984) comprised of statements rated on a 7-point Likert-type scale which ranged from 'strongly agree' to 'strongly disagree'. Qualitative questions were asked at posttest to obtain respondents' feelings about the homemaker service. Because research of this kind has not been done at Richmond Health Department's Continuing Care Program, the author's decision to conduct an exploratory descriptive study is an attempt to 'explore' whether a relationship or association exists between subject perceived well-being and homemaking services, and to 'describe' the sample demographically.

SAMPLE

Due to time constraints and feasibility of access to subjects, the sample was based on the availability of 30 people registered with the Continuing Care Program and assessed
to qualify for homemaking services. In general, non-probability sampling methods are regarded as less reliable and not generalizable. Because subjects had to be recruited as they came into the program to meet the criterion of being clients who had not yet received homemaking help, the researcher decided to use a convenience sample for this study. Other criteria for participation in the study were the age of 65+, a minimum of 26/30 on the Mini Mental Scale administered by the researcher at time of assessment, and living in the community. This was essential because the focus of the study was to measure perceived well-being before and after the intervention of homemaking services. The writer verbally confirmed the physical conditions of all subjects with their physicians as part of the initial qualification for service assessment was completed.

The British Columbia Long Term Care/Continuing Care Program defines five different levels of care to clients. Each level of care can be provided at home or in a facility. Referrals are received by Continuing Care from physicians, nurses, social workers, family and friends. Decisions about level and place of care are based upon assessments performed by trained CCD staff - either social workers or other experienced community health professionals.

Subjects in this study were assessed at various levels of care. These levels of care assist in determining the amount and frequency of assistance to be allotted the client, and the rate of payment for residential care and facility placement. Care levels are determined by established criteria and not on the basis of perceived need. For example, a client assessed at the Personal Care level (PC) is independently mobile, with or without mechanical aids; mentally intact or suffers only minor mental impairment. The PC client requires only minor assistance with self-care but does not require regular medical supervision.

Persons assessed at the Intermediate Care 1, (IC1) level of care, are independently mobile, like those requiring Personal Care, but require some health supervision and some assistance with activities of daily living. Estimates suggest that people in this category of care require 75 minutes of individual attention per day: fifteen minutes from a professional, and 60 minutes from a non-professional.

Client characteristics at the Intermediate Care 2 level, (IC2), resemble those in the IC1 level of care, however, the estimated amount of care needed increases to 100 minutes
of daily individual attention: thirty minutes by a professional and 70 minutes by a non-professional.

There are two other levels of care: Intermediate Care 111 (IC3), and Extended Care. The former was designed to recognize the client with severe, continuous behavioural problems, who needed more daily care, and the latter provides round-the-clock supervision of clients.

The subjects in this study ranged from PC (personal care) levels to IC2 levels (Intermediate Care 2). Some subjects received homemaking once a week, while others received homemaking every other week, depending upon their assessed levels of care. Fourteen of the subjects were assessed at the PC level of care, and received homemaking services every other week for about 2 hours, 11 subjects were rated at the IC1 level of care and received homemaking once a week for 2 hours, and the remaining 3 subjects were assessed at the IC2 level of care and received homemaking once a week for 2.5 hours. The higher the level of care, the more assistance usually required. Each subject was interviewed after 6 homemaking visits. In some cases this meant after 6 weeks and in others it meant after 10 to 12 weeks. This had the potential to complicate the study because of elapsed time; however, careful attention to interviewing and review of significant events and changes that occurred over the span of several weeks served to minimize effects of extraneous variables.

**Initial Recruitment**

The original plan was to have Case Managers from the department assess all clients for homemaking services after which they were to either ask them or present my letter inviting their participation in the research (Appendix A). If clients did agree to participate, a more detailed letter (Appendix B) was then presented by the Case Manager explaining the study and methods. Clients were not required to sign a consent form to be part of this research project. Verbal agreement was acceptable to Ethics Committee in this regard. This original plan did occur with four of the subjects, but heavy caseloads and
other priorities prevented Case Managers from assessing and interviewing clients within the researcher's time constraints. As a result, the author was engaged by Continuing Care, and she recruited the other 26 subjects by asking them to participate in her study and showing them the explanatory letters (Appendix A and B) after assessment-for-service interviews. A positive verbal response to this request constituted subject consent as in the previous 4 subjects assessed by other Case Managers. Sample size was limited to 30 due to subject availability and time constraints of this study. Although 30 subjects were initially recruited, two were withdrawn from the study because of acute illness, hospitalization and cancellation of homemaking services.

Because of the convenience sample, it is not possible to generalize the results to other populations, but it is anticipated that data may be similar to that of other clients in the Continuing Care Program and may serve as a basis for further evaluation of the program.

**Recruitment Procedures**

There was 100% positive response when the thirty clients were asked if they would like to participate in this research. This may have been because this age cohort is known to be desirous of reciprocation particularly if they feel they have been the recipients of assistance, kindness or aid from others (Rodgers et al., 1988). In her 1989 study, sociologist Hazel MacRae, noticed that: "as respondents talked about themselves and their lives, 'doing for others' was such a pervasive reference . . . . that it appeared to be a fundamental element in the ideology that was shared by many, if not most of these women" (p.263). The internationally renowned psychiatrist, Viktor E. Frankl (1962) wrote about the importance of discovering meaning in life by "doing a deed" or fulfilling what one interprets as task or purpose in life. The researcher explained at time of recruitment that participation in this study could render valuable data which may serve to improve the quality of services not only to themselves but also to others who utilize the Continuing Care services, and that this study was part of the writer's master's thesis. This explanation seemed to render a
willing positive response, and I perceived that their doing things to help others appeared to be an important aspect of their interpretation of their meaning in life, and the part they were going to play, just as Frankl (1962) suggested in his book *The Meaning of Life*.

Another interpretation of the excellent response rate of subjects in the present study is the possibility that clients may have felt threatened by thoughts of potential loss or withdrawal of homemaking services if they did not participate, particularly as the researcher was also the assessor. Appropriate steps were taken to acknowledge these potential problems and although it did not appear to be required, subjects were reassured many times throughout the interviews that services would not be affected if they chose not to participate further in this study.

The principal characteristics of age in Erik Erickson’s (1964) theory influenced this writer who had hoped at the outset to be able to appeal to older adult’s sense of generativity; in other words: “involvement in establishing and guiding the next generation. It entails an expansion of ego interests - a giving of oneself to those who are younger or to involvement in work deemed of personal value and set as a goal” (Burdman, 1986, p.90). Butler et al. (1991) refers to this as the ‘elder function’ which they describe as “a natural propensity for the aged to share with the young the accumulated knowledge and experience which they have collected” (p.80). It is important to the self-esteem of an elder to be acknowledged by younger individuals and to have his or her life experience seen as interesting and valuable to others. We perceived 90% of the subjects at Time 1 to be enthusiastic because they reported the experience to be enjoyable. Several subjects expressed delight at being the topic of such an important area of investigation and felt they had a vested interest in the study.

When subjects agreed to participate during the assessment, the author arranged to meet with them in their homes at mutually convenient times before the homemaking service started in order to record a baseline measure of their perceived well-being. No one raised any negative concerns about the research or his/her participation; the researcher perceived respondents at Time 1 to be enthused by at the prospect of being involved in a research project. Six homemaking visits later, or six to twelve weeks after homemaking
services began, in some cases (because of assessed levels of care), subjects were contacted by telephone to arrange for the second administration of the well-being measurement and a qualitative interview, regarding their feelings about the service. All interviews were conducted by this writer. The following diagram displays the repeated measures design.

<table>
<thead>
<tr>
<th>Repeated Measures Design</th>
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<tbody>
<tr>
<td>Time 1 Interview --------</td>
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<tr>
<td>PWB Scale</td>
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Following is a description of the homemakers and objectives of the service, and Table 2 illustrates the Richmond Homemaker Characteristics.

**HOMEMAKER PROFILE**

**Objectives of the Service**

Homemaking services, often regarded as "a promising alternative to institutionalization" (Barer, 1992, p.130), provides care with a view to enhancing quality of life by encouraging the self-worth and dignity of people, helping them to attain the highest level of 'well-being' possible, and by facilitating as much independence at home and in the community as possible. These goals are achieved through several tasks:

1. Meal preparation
2. General house cleaning (vacuuming, kitchen and bathroom cleaning, laundry, mopping floors, dusting, window washing)
3. Assistance with personal care (hands-on bodily care such as bathing, hair washing, dressing)
4. Social contact and emotional support

5. Activity assistance (toileting, transferring in and out of bed etc.)

All 28 subjects in the present study were receiving general cleaning services which involved vacuuming of rugs and floor, mopping floors, washing of sinks, tubs, and toilets, washing the kitchen sink, surfaces, window cleaning, stove, oven, and refrigerator cleaning and defrosting, laundry and special tasks designated to assist disabled clients. For example, one rheumatoid arthritis sufferer needed her kitchen cupboards cleaned and re-organized because of her inability to lift her arms over her head, and the homemaker did this especially for her. Twenty-one percent of subjects (6) received assistance with bathing, hairwashing, dressing and undressing, and toileting. Meal preparation was performed for twenty-five percent (7) who required help with preparation of a light sandwich at lunch, or some vegetable peeling which painful arthritic joints prohibited. Five subjects (18%) required assistance with transferring in and out of bed. The writer will presume that all subjects received social contact.

Homemaker Characteristics

The two homemaking agencies in Richmond were contacted by the writer to obtain demographic information about the homemakers' age, gender, education, income levels, marital status, cultural background and the average number of clients seen by them. Table 2 illustrates a brief summary of such variables: this is a general overview of some of the characteristics of the homemakers who work for the Richmond agencies, and representative of the type of homemaker who performed services for the subjects of this study.

The actual homemakers themselves were not considered in this study, rather it was the measures of perceived well-being of clients after receiving homemaking services that were the primary focus. The variables in homemaker may well have had an effect on the well-being of clients, but since this study was less interested in the homemaker per se
Table 2
Homemaker Characteristics - Richmond Agencies, 1993

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>30 years of age or less</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>30 - 45</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>45 - 55</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Over 55</td>
<td>9</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Females</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>2</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>European</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Filipino/Chinese</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Indo/Pakistani</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Japanese</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Caucasian</td>
<td>53</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>High School</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Postsecondary</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Health Care Related</td>
<td>37</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Single</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Support Worker Categories</strong></td>
<td>License Practical Nurse</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Home Support Aid</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Uncertified Home Support</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Worker</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Registered Nurse</td>
<td>3</td>
</tr>
</tbody>
</table>

Each homemaker has an average of 5 clients.

and more interested in the effect of homemaking services on client well-being, these variables were not taken into consideration for this study. Time constraints and resources contributed to this decision. A study comparing the homemaker demographics with client characteristics may yield some very important data to contribute to this relatively new area of research. A number of researchers (Barer 1992; Brothers and Mullaney, 1980; Eustis et al., 1991; Fashimpar and Grinnell, 1991; Matthews and Wakefield, 1992; Tobin et al., 1983; and Chichin, 1992) have contributed to the sparse knowledge on this topic.
DATA COLLECTION

Data in the study were gathered by means of face-to-face administration of the PWB (Perceived Well-Being) Scale before and after 6 homemaking visits. In conjunction with the administration of the PWB Scale at Time 2, a qualitative interview was used in this repeated measures design. The researcher travelled by automobile to each of the thirty respondents' homes at pre and posttest. (30 at pretest and 28 at posttest).

The reason for face-to-face interviewing was twofold: 1) acknowledgement of other researchers' reports of very poor response rates to mail-out questionnaires (Rubin and Babbie, 1989), and 2) telephone interviews were discouraged by the Ethics Committee at the University of British Columbia. Although self-administered questionnaires guarantee anonymity, in-depth information and people's views from face-to-face interviewing techniques often enrich the data (Cozby, 1985) and enhance research quality. As well, due to the explanatory nature of this study it was important to begin to find out how the subjects felt about their homemaking services.

As was discussed in the previous chapter, subject recruitment was not difficult. Contact with subjects was pleasant, although time-consuming during both Time 1 and 2. Appendix K illustrates an example of the sheet I read when I telephoned subjects for the initial appointment after other assessors completed the four qualification-for-service interviews and gave a standardized introduction to the study (Appendix A). The telephone introduction in Appendix K was not used for the remaining 26 subjects after I was hired as assessor. Because I assessed the remaining 26 clients for services personally, I asked them at that time to participate in my study after I had completed the assessments. Specifically, I offered each client the following explanation:

Mrs/Mr ___ : As well as working as an assessor for Continuing Care, I am also a full-time student at UBC and am currently working on my masters thesis. My research involves the effect of homemaking services on clients like yourself. I would like to invite your participation in this study because information you offer may help us to improve the quality of services not only to you, but also to others who utilize the Continuing Care services. I have a more detailed letter of introduction of my study that you may like to read and if you would like to participate we could make arrangements for an interview appointment at your convenience.
During Time 2, subjects willingly responded when I called for follow-up interviews, and with the exception of two ladies, who were not as enthusiastic as the first time, the posttests took place without problems or hesitation on the part of subjects. The two ladies who were not as enthusiastic were experiencing a downturn in their health, and were feeling apprehensive about upcoming diagnostic tests and outcomes. They did, however, agree to finish part two of the survey, and I spent some extra time with them afterwards in de-briefing sessions to make sure they were not further traumatized by the interview.

**Quantitative Measure**

The Revised 16-statement Perceived Well-Being Scale (PWB) (Reker and Wong, 1984) illustrated in Appendix E was utilized in this study. Each statement was rated on a 7-point Likert-type scale ranging from "strongly agree" to "strongly disagree". This 16-item scale allows for the separate assessment of psychological and physical well-being in elderly people. The author considered other scales available for measurement of well-being, but few were designed with the geriatric in mind. It was deemed that research instruments be compatible with the elderly in terms of length and comprehension. The PWB Scale according to Reker and Wong (1984), "is brief enough to make it a useful screening device to identify the elderly who are either low or high on the wellness/illness continuum" (p.30) The PWB was chosen for this study not only because of its brevity, but also because of the two categories of psychological and physical well-being, which most other measurements of well-being do not include.

This brief 16-item scale was constructed particularly for community-dwelling and institutionalized elderly people. Reker and Wong (1984) constructed the PWB because of the apparent need for an instrument that was "broad in scope but sharp in focus" (p.29). Additionally, in an attempt to inject Canadian content into this study, this instrument from Trent University in Ontario met with this researcher's criterion.

Reker and Wong (1984) tested this scale on 238 community and institutionalized elderly people and demonstrated high internal consistency and stability:
psychological well-being = .82
physical well-being = .78 (for factor scores)
general well-being = .91

Test-retest reliability on psychological well-being = .79 (p < .001); physical well-being = .65 (p < .001), and general well-being = .78 (p < .001). Reker and Wong (1984) report that the validity of the PWB is deemed sufficiently high to justify its use with the elderly. Samples of community elderly (N=20) and institutionalized old people (N=24) were used to test for validity. In another study by Reker and Wong (1982), the PWB is reported to have held up extremely well in work with the elderly on perceived coping behaviour and well-being. "Its ecological validity makes it a useful instrument in longitudinal and intervention studies regardless of whether the elderly reside in the community or the institution" (p.30). A study investigating optimism, meaningfulness, and well-being reported equally reliable and valid results (Reker and Wong, 1983). Pretesting of the PWB was conducted on 6 similar elderly subjects in the community with acceptable reliability levels of .76 for psychological well-being, .64 for physical well-being, and .78 for general well-being.

Quantitative Procedure

The Perceived Well-Being Scale (Reker and Wong, 1984) was administered at both visits verbally by the writer. Each item from 1 to 16 was read out loud to the subjects by the researcher. This was done because of hearing and visual impairments, poor dexterity of many subjects, and because of the concerns around interpretation of instructions on the PWB scale. Although this method takes longer to administer, the writer feels the information is more reliable because it gives subjects time to understand the statements and think carefully about their responses. Demographics about age, gender, income, education, living arrangements, marital status, and illness were taken as part of the first assessment interview for services.

Each of the 16-item subjects' responses to the statements was circled on the response sheet by the researcher with a blue marking pen. One statement sheet was used
per subject. Subject names and phone numbers were listed on his/her statement sheet until the data was coded; names and numbers were then erased, to ensure subject confidentiality. Responses ranged from strongly agree, moderately agree, agree, undecided, disagree, moderately disagree, and strongly disagree. Only one response per statement was allowed. The responses were tallied according to the score value for each response (Appendix F). A psychological and physical well-being score was recorded at the bottom of the scale, and these two scores added together to obtain the General Well-Being Score. The resulting general well-being score is a combination of psychological and physiological well-being scores. The lowest score possible on the psychological and physiological well-being measures is 8, while a high score of 56 is possible. In the general well-being category, the possible range of scores is from 16 to 112. Notes were made, if appropriate, about significant responses to statements to be considered in later analysis. For example, if a statement elicited tears, apprehension, laughter, the response was noted and dated in blue marking pen.

At Time 2 the same procedure was followed but responses this time were circled in red pen on the same sheet and subjects were also asked the 4 questions from the qualitative format illustrated in Appendix L. This enabled the researcher to note any significant changes, between Time 1 and Time 2. Once again responses were tallied up and recorded at the bottom of the page. Notes were made about significant responses, to be considered later in analysis. When the test administrations from Time 1 and Time 2 were completed the variables were codified on a Fortran sheet for data entry into the SPSS-PC+ system, for data analysis, using the Wilcoxin Sign Test.

Forty-five minutes was allotted to each interview at Time 1, and one and a quarter hours at Time 2. Average time was 1 hour for Time 1 and 1.5 hours for Time 2. Many interviews exceeded the allotment by up to one hour. This problem did show up during pretesting of the instruments. The reason for the extra time was because I allowed subjects to talk about circumstances in their lives that led to their present situations. Hessler (1992) maintains that “in order to effectively establish rapport, maintain control, and do all of the myriad other things necessary to conduct a successful interview, understanding the
respondent’s perspective is critically important. . . rather than trying to forge ahead with the interview forsaking the respondent’s perspective, you need to call a temporary halt to the plan and spend some time learning about where the respondent is coming from” (p.139). It is extremely important in this phase to resist the desire to “do social work” with these people, however. This is essential to the robustness of the study. Steps were taken to try to stay within the confines of time but these older respondents had a tendency to elaborate, digress, and generally took more time to form their thoughts and responses.

The writer was aware and carefully attempted to control for experimenter bias or expectancy effects she might have been unintentionally exhibiting by attempting to display consistent behaviour with all subjects during the interviews, and by conducting the interviews using a routine by asking the questions in the same order. However, this may not be enough because bias can be unintentional - in other words, the experimenter may not be aware of his or her influence. Another solution to this problem would have been to run all conditions simultaneously so that the experimenter’s behaviour is the same for all subjects, however this solution was not feasible in this study. When running simultaneous groups is not possible, one might consider using interviewers who are unaware of the researcher’s hypothesis, or the blind technique (Grinnell, 1985). However, this was not a feasible solution for this study. In order to accomplish this the writer would have required additional interviewers to help conduct her research, so she conducted all the interviews herself at Time 1 and Time 2, and was as accurate and consistent in behaviour and interviewing routine as possible. As well, use of standardized qualitative format helps to control for the experimenter bias effect (Patton, 1990).

**Triangulation**

The decision to triangulate the data by introducing a qualitative component to the quantitative methodology was based upon the premise that the subjects are the experts. If changes did occur in established measures of perceived well-being, the writer felt that the subjects themselves would be the most qualified to identify, illuminate, and elaborate as to
why changes may have occurred. Because this research is an exploratory descriptive study of effects of homemaking services on client well-being, a decision was made to conduct these qualitative interviews by asking the four open-ended questions illustrated in Appendix L with a view to illuminating the quantitative data results. The subjects were not given 'carte blanche' in offering information, however. In other words, they were not encouraged to elaborate about issues other than the question at hand. They were given adequate time at the start of the interviewing to allow the researcher to gain a sense of their current health status and life circumstances. They were encouraged by the structure of the question to elaborate on one particular issue at a time with appropriate probing and re-direction, if needed, from the writer. This was important because of the writer's interest in their opinions about homemaking service. To reiterate, the 4-question interview was used as an adjunct to this primarily quantitative study. The injection of the qualitative element is to enhance, strengthen, and aid in interpretation of the quantitative data by tapping into and interpreting the deeper meanings subjects' experience. Too often, it seems, elderly clients' assessments of homemaking services go unaddressed. Studies have often focused primarily on policy issues, quality of care, and cost effectiveness (Weissert et al., 1988; Weiler, 1974; Herdman and Kerr, 1975; Walton and McNairn, 1978). But clients frequently are "passive recipients" and from an exploratory point of view, it seemed appropriate to this researcher that first-hand information should be derived from the experiences of clients who receive services.

Unfortunately, time and resources were scarce. This could be viewed as a limitation when attempting the principle of triangulation. Many researchers would advocate for one or the other with the strong advice that justice cannot be afforded both without adequate time; however, for purposes of this project, the element has been injected.

Qualitative Procedure

During the qualitative aspect of the data collection, 6 interviews were taped and transcribed with permission of subjects, and the other 22 interviews were recorded by
note-taking. This method can be limiting because of the inability to make observations at the same time, and the possibility of inaccurate recording.

Ten subjects from the four categories of marital status and living arrangements were selected by the researcher for recording because of the desire to have a representative sampling within the sample of the different categories of subjects: married, widowed, single, and separated. Names from each category were put into a box, then randomly chosen by the writer. The decision to choose 10 subjects was a consequence of the writer's time and resource limitations. Four out of ten subjects approached the idea of being recorded somewhat reluctantly, and with varying degrees of apprehension. Although I assured them of my commitment to their confidentiality, some said that they preferred their responses not be recorded on tape. Perhaps subjects felt that their homemaking service would be in jeopardy, and perhaps because they took their participation in this study seriously, they felt they could not answer the questions as candidly on tape.

Studies on cautiousness of the aged suggest that the older adult is more cautious that the younger adult. Two explanations were given for this. First it was believed by Jack Botwinick, a researcher in this area, that the older people were more conservative than young adults, and were less likely to take chances. Secondly, it is also believed by some scholars that the self-image of the aged is more unstable that their younger counterparts. It is believed for this reason that the older subjects prefer not to risk making a mistake that might further reduce their low self-image (Botwinick, 1966; 1977). Conversely, other studies on cautiousness suggest that the elderly are not as cautious as the young adults (Botwinick, 1973; Okun and Elias, 1977). Botwinick (1973) reports that the elderly simply choose the 'no risk' items in tests more frequently than younger adults, and therefore give the false impression that they are more cautious than younger adults. This researcher was concerned about the instruments used in cautiousness studies.

As we know, in the measurement of older people, instruments must be elder compatible, and this may not have been compensated for in past studies of cautiousness. However, in the present study the issue of recording by tape machine was not pursued aggressively as I wanted to avoid all discomfort on the part of my valued participants.
Appendix D illustrates the initial qualitative format which was pretested on 4 individuals and was subsequently restructured to the present format. The questions not only were closed-ended but were too leading, and elicited many one or two-word answers. The writer was aware immediately that the structure was not conducive to elaborate accounts and it was re-structured. The re-structured format in Appendix L included open-ended questions which elicited descriptive responses.

Although the qualitative technique can be time-consuming for the researcher, it can often yield very important information rich in detail. Personal interviews can also enable the researcher to make valuable observations about subjects and their environments which have the potential, as a result, to add to the data interpretation and analysis. Ideal research might interpret results from both quantitative and qualitative methods of evaluation. In fact, researchers of today are looking more favourably upon this concept of triangulating data (Patton, 1990; Norris, 1993).

As with quantitative methods, there are advantages and disadvantages to qualitative interviewing. Following is a list of those which this researcher experienced while using personal interviewing techniques. These were chosen as each interview progressed.

**Advantages of Personal Interviewing**

- more flexibility in asking questions
- data tends to be richer in information
- a more effective way of enlisting the co-operation of respondents
- advantageous interviewer administration - i.e. probing, answering respondents questions, clarifying instructions and meanings
- rapport and confidence building more feasible
- longer interviews can be done in person
- multi methods of data collection - i.e. visual cues, observation of subject in his/her own environment, body language
**Disadvantages of Personal Interviewing**

- difficulty generalizing results to other populations
- difficulty analyzing large masses of information while addressing issues of efficiency and effectiveness
- costly (travelling time, gas, car maintenance, time)
- data collection period is longer than telephone procedure
- subjects often difficult to access (hard-to-find areas of the city and buildings)
- costly transcriptions (typing fees, equipment rental and failure)
- interviewer effects unknown

**DESIGN LIMITATIONS**

*Availability sampling* was one of the major limitations of this study and design. Uncontrolled sampling produces some obvious sample biases: the direction of availability and willingness to be interviewed. Normal assumptions for calculating sampling errors do not apply in this study. Further studies of this type drawing from a large random sample might yield generalizable results.

*Demand characteristics,* or the knowledge of the questionnaire subjects gained after test one, was another design limitation in this study. When the same subjects participate in both groups they often can determine the true purpose of the experiment (demand characteristics). This researcher took precautions not to give away the main reasons for interviewing the subjects, through subtle eye contact, body language, verbal intonations, and such.

*Social desirability* is another problem of the design. It is very important to be cognizant of respondents giving answers they think the interviewer wishes to hear
(Cozby, 1985). This might have been controlled for by the use of a separate social desirability scale in conjunction with the PWB, however, constraints and resources did not permit the application of such measures in this study.

**Mortality** or the possibility of drop out, is a disadvantage of the repeated measures design; that is to say, if an experiment or condition runs over an extended period of time, the subjects may be lost for various reasons. Mortality is a threat to internal validity when the mortality rate is related to the nature of the experimental manipulation (Rubin and Babbie, 1989). This writer was mainly concerned about ‘drop out’ due to severe illness, hospitalization and even death, because so many respondents were seriously ill. This was one of the main criteria for setting the re-testing after only 6 homemaking visits, and not four or 5 months. In fact, two of the initial 30 subjects were lost: one due to stroke and hospitalization and subsequent surgery, and the other had to be eliminated from the survey because of several suicide attempts and hospitalization. This left a total of 28 subjects to complete the study.

**History** can be a threat to the internal validity of a study. This term refers to any outside event that is not part of the manipulation that could be responsible for the results (Grinnell, 1985). In the repeated measures design it is almost impossible to control for history and during the second interview considerable effort and time were allotted to careful inquiry about significant changes that may have occurred in subjects’ lives which may have invalidated results. Significant events and/or changes have been documented and will be taken into consideration during data analysis.

**Maturation** refers to the possibility that any naturally occurring change within the individual is responsible for the results (Cozby, 1985). This is a problem in this repeated measures design because it has the potential to result in change from pretest to posttest. For example, people change over time; they become fatigued, bored, and wiser.
Testing can be a problem if simply taking the pretest changes participant's behaviour. Taking the test may enable the subject to become aware of the attitude being tested, and make them more 'sophisticated' about the matter in question, or more adept at the skill being tested - if this occurs, the experiment would not have internal validity (Rubin and Babbie, 1989).

The above problems or pitfalls can be controlled by the use of a sufficiently large sample and appropriate control groups, however, because of resource and time limitations a control group was not feasible for this research project.

**ADVANTAGES OF THE METHODOLOGY**

The repeated measures design also has its strengths. When utilizing repeated measures, one follows the same group over at least two points in time (Rubin and Babbie, 1989). This design is predicated on the theories that the social system is dynamic and it seeks to explain change (Hessler, 1992). Since this study is investigating whether or not perceived well-being is affected by homemaking service, the researcher deemed it essential to obtain a baseline reading of 'well-being' before the services started and several visits afterward in an attempt to detect any changes in the measure.

Biddle et al. (1985) argued that the repeated measures design is the only real alternative to the experiment which is viewed by some as flawed due to its artificiality. An obvious advantage of the repeated measures design is that fewer subjects are needed because each subject participates in all conditions. This is useful when subjects are scarce, as was the case in attempts at recruiting applicants for homemaking services. Another advantage to this repeated measures design as that it is extremely sensitive to finding differences between two groups (Cozby, 1985). Because subjects in the group are identical
in every respect (they are the same people), error variability due to subject differences was minimized.

To achieve internal validity in this study (results valid within the confines of the experimental procedure used) was an unrealistic goal. Random sampling techniques were not employed. The use of control groups or control of extraneous variables through matching or manipulating the research environment were not considered in this study primarily because of resource and time constraints. To match all subjects on all variables would have been a very costly undertaking in terms of time and resources. The primary goal of this exploratory descriptive study is to try to determine whether a relationship between homemaking and perceived well-being of subjects exists. With generous time and resource allotments, random sampling and control groups would certainly be a primary objective, if this study is to be replicated and produce generalizable results.

DATA ANALYSIS

Quantitative PWB Scale

Each of the 16 statements on the Perceived Well-Being Scale was administered orally to subjects. Each item was rated on a 7-point Likert scale.

Statement numbers 2, 5, 8, 12, and 16 are negative statements relating to psychological well-being. Scores ranged from 1=SA (strongly agree) to 7=SD (strongly disagree). Item numbers 7, 10, and 15 are positive statements and scores ranged from 7=SA (strongly agree) to 1=SD (strongly disagree).

Statement numbers 1, 3, 6, and 11 are negative physical well-being statements and scores range from 1=SA (strongly agree) to 7=SD (strongly disagree). Whereas, statement numbers 4, 9, 13, and 14 are positive physical well-being statements and scores range from 7=SA (strongly agree) to 1=SD (strongly disagree).
The lowest score in both psychological and physical well-being is 8, and the highest achievable score is 56. The sum of psychological and physical well-being scores equals the general well-being score. The lowest general well-being score is 16 and the highest is 112.

Subjects were asked whether they strongly agree, agree, moderately agree, were undecided, moderately disagree, disagree, or strongly disagree with each of the 16 statements. A score of 7 on each item reflects a high level of well-being. Scoring instructions for the scale are illustrated in Appendix F.

In order to try to detect a change in well-being scores, the scale is administered twice: before intervention and after, then the two scores are compared.

Comments or reactions made by subjects about a particular statement were recorded on the statement sheet by the statement and dated. These comments were compared with comments or reactions at Test 2 and incorporated with the qualitative data.

**Qualitative Analysis Procedure**

The six persons who agreed to taping represented the different marital status categories of the total sample (married, widowed, single, separated subjects). Data was transcribed the same day it was recorded and read for meaning on that same day when possible; a typist was hired to do this work, and often it meant reading the transcriptions the next day.

The data from the other 22 subjects whose thoughts and opinions were recorded by taking notes was collected daily until all subjects had been administered the PWB Scale and qualitative questionnaire after 6 homemaking visits. The information was read for elaboration the same day it was collected, while the experience was still fresh in my mind.

Due to limited time and resources, and because it was desirable to have the same information from each individual interviewed, the standardized open-ended format illustrated in Appendix L was used and each subject was asked exactly the same questions in the same order at Time 2. The questions were composed in advance exactly the way
they were to be asked and careful consideration was given in the wording of each question in order to increase data credibility and to prevent the kind of problem that occurred during pretest when questions were not open-ended and/or were too leading, and subjects answered questions in one and two words. The rationale behind the standardized open-ended interview according to Patton (1990) is to "minimize interviewer effects by asking the same question of each respondent" (p.285). As well, Patton (1990) recommends that standardized open-ended questions facilitate analysis and organization of data.

The interview at Time 2 consisted of the administration of the Perceived Well-Being Scale, and then the subjects were asked the four questions from the qualitative format. Subjects were directed to answer the questions as thoroughly as they could and were gently redirected if or when they digressed from the topic and kept focused so that interviewee time could be carefully utilized.

The first question of the qualitative format: What, if any, significant changes have taken place in your life over the past 6 (8 or 10) weeks, was asked with a view to obtaining background information about significant events which may have occurred in the subjects' lives during the period that the homemaking services were being carried out. This question allowed the researcher to control for confounding variables which may have contributed to the change in PWB scores (the first objective of this study). I was looking for happy events such as gains, special occasions, good news, improved health, and sad occasions, disappointments, deterioration in health, and losses which may affect one's life, or even uneventful periods.

Question 2, What is your opinion of the homemaking service is an opinion or value question aimed at understanding the thoughts subjects had about the service of homemaking. This question was asked with a view to obtaining the answer to the third objective of this study: to determine subjects' feelings regarding the homemaker and service. This is an important question for the Continuing Care because it has the potential to speak to their mandate.

Question number 3 of the qualitative format, How do your view your homemaker, is another opinion/value question which attempts to obtain and understand subjects' thoughts
and interpretations of their homemakers. This question was asked to gain an understanding of any changes in well-being scores which may or may not be associated with the homemaker, and in an attempt to answer to the third objective of this study.

The last question was, *What would you like to see happen that might improve the homemaking service for you and/or other elderly clients of Continuing Care?* This question was designed to be a knowledge question: one which attempts to elicit the subject's factual knowledge of the service he or she has received. I asked this question to determine what recommendations recipients of the homemaking service offered.

The weakness of the standardized approach is that it does not permit the researcher to pursue subjects' issues or concerns that were not anticipated during the composition of the qualitative questions. The strength of this format is the reduction in interviewer effects and bias, particularly if more than one interviewer is used; all subjects are asked the same questions and the ability to compare responses is greater, and finally, this format facilitates the organization and analysis of data (Patton, 1990).

The qualitative data was classified for content analysis in order to facilitate a search for patterns in subject responses. Content analysis according to Patton (1990) "is the process of identifying, coding, and categorizing the primary patterns in the data" (p.381). Notes were made during the administration of the PWB scale at Times 1 and 2 in the margins of each subject's PWB test sheet. These notes were included in the data analysis if they had relevance to the study. For example, if a subject shed tears during his/her response to a particular statement I wrote "Client tearful" in the margin next to the item number.

After reading through all the transcribes and my own notes twice, and making comments in the margins about my own ideas of what I thought the subjects were saying, I went back to the first transcribe and began to give recurring ideas and concepts in the data a label and coloured the idea or concept with a coloured felt pen and added the label at the side of the paragraph in the same colour. Coding was done for each question.

For example, the following excerpts are illustrated to clarify the coding process. These examples are from Time 2 interviews with subjects who were responding to
question 2: *What is your opinion of the homemaking service?*

Oh, well, we were brought up that way . . . you didn't get to go out until you did your part of the chores. I had to clean the bathroom and my sister did the steps, and cleaning day was on Friday and baking was on Saturday, and my father liked everything in its place you know, and we had to get it done right . . .

The codes I used for the above statement were *learned behaviour* and *gender roles*. This concept alludes to the way the subject was brought up in her family to carry out her duties as a young girl in the family. It also conveys the expectation of the male figure, and the acknowledgment by the female of her role at this time. This coding procedure reflects the content, or embodies the meaning of the text in terms of a concept. Another example from the data is the following:

Oh yes, well you can imagine how it feels to sit here and look at the dust pile up and not be able to do anything about it, I mean . . . don't ever let anybody tell you about the golden years . . .

The concepts which I formulated from the above comments made in answer to question 2 were *loss of control* and *disappointment*. Learned behaviour, gender roles, loss of control and disappointment were recurring ideas or concepts in other respondent's responses to this question. When all the data for each of the four questions was labelled or coded, the researcher re-read the interview notes and transcribes with a view to searching for common themes within each question. Because the qualitative interview consisted of four questions the patterns or categories were in a sense imposed prior to data collection. Specifically, the writer was looking for answers to questions about the homemaking service and the homemaker. So, for example, it was anticipated that when asking the question: *What is your opinion of the homemaking service*, an opinion answer would be forthcoming. Of course, the type of opinion is not known or anticipated and during coding, one looks for patterns, themes or categories which may emerge in the response to this question.

Following is a list of the four questions. Examples from the concepts derived from the data in those questions are listed in the left-hand column and those which relate to common themes are clustered. The right-hand column states the themes and the plus (+)
signs in front of a theme indicate additional information from notes during administration of PWB at Time 1 and Time 2.

1. What, if any, significant changes have taken place in your life over the past 6 (8 or 10) weeks?

   Concepts
   sense of control
   feeling of normalcy
   fortunate
   improved health
   fear
   uncertainty
   deterioration
   helpless
   dependent
   humiliation
   frustration
   peace of mind
   less isolated
   less worry

   Themes
   improved self-perception
   improved health perception
   + decreased sense of self
   + vulnerability
   + anxiety
   diminished function/mobility
   + decreased anxiety

2. What is your opinion of the homemaking service?

   Concepts
   decreased pressure
   fulfilled needs
   reassured
   wonderful thing
   increased confidence
   pleasing
   not intrusive
   good service
   helpful
   intrusive
   inadequate scheduling
   poor quality work
   loss of independence
   loss of autonomy
   useless
   regained pride

   Themes
   feelings of relief
   satisfaction
   criticisms
   disappointment
   + decreased self-concept
   loss of control
   value of housekeeping
regaining social contacts  
expectations  
standards  
renewed confidence  
gender roles  
learned behaviour  
+sense of identity

3. How do you view your homemaker?

**Concepts**  
the girl, my girl  
friend  
godsend  
real gem  
the worker  
the homemaker  
the maid  
young girl  
my helper  
a real princess  
reliable  
sympathetic  
pleasant  
thorough  
self-directed  
willing  
hard-working  
understanding  
attached to her  
miss her  
accustomed to her  
desire to keep her  
someone to talk to  
dislike her

**Themes**  
labels  
homemaker qualities  
clients' feelings

4. What would you like to see happen that might improve the homemaking service for you and other Continuing Care clients

**Concepts**  
schedule changes  
different homemakers  
variation on quality of work  
no control  
lack of client input

**Themes**  
lack of continuity  
passive recipient
This process of listing concepts and clustering into themes was less complicated than many processes of qualitative analysis, because of the pre-imposed question format, and the exploratory nature of the study. The researcher was looking for opinions to specific questions and there was less need for 'interpretation' of responses. Rather, the intent was to record the answers to the 4 questions as subjects reported them and identify common responses or new patterns which may emerge. This information was used to enhance the quantitative data.

Notes made during the administration of the PWB scale were coded and added or "fitted in" to the concepts of the qualitative data. For example, in statement # 2 of the PWB: No one really cares if I'm dead or alive, a note in the margin of one subject's sheet said: Client tearful. Another response to statement 16: I'm afraid of many things, elicited comments such as, Well I'm always afraid of ending up in one of those nursing homes, or I don't like being alone at night, or I'm afraid for my grandchild's future. All of the "notes to myself" were gathered and listed by subject number, and some of relevance were included by entering an "+" beside the themes derived from the qualitative format on the previous pages to designate added information from "notes to myself".

Other comments were frequently gesticulation about the wording of the items like # 7: It's exciting to be alive or # 9: I'm in good shape physically. Comments were directed at the author of the PWB Scale and not the researcher. These comments and gesticulations may be forwarded to Reker and Wong with a view to improving the scale. However, I did return to these side notes consistently during the analyses to see if their significance was appropriate to this study.

Notes were compared with each subject's scores for discrepancies. For example, I was looking for differences in scores and data from the "notes to myself " - a high score in well-being would be inconsistent with tearful comments of hopelessness and despair, and vice versa.
Chapter V

RESULTS

DESCRIPTION OF THE SAMPLE

Age

Thirty subjects agreed to participate after being asked by the researcher and/or shown a letter inviting their participation in the study (Appendix A), and twenty-eight respondents completed the study. Ages of the twenty-eight subjects ranged from 65 to 87 years, with a mean of 75 years and a standard deviation of 6.0948. The median is 74.5. The distribution is trimodal: mode 1=71 years, mode 2=73 years, and mode 3=84 years of age. Table 3 depicts the cumulative frequency distribution of ages. Age groupings of subjects are illustrated in Figure 2.

<table>
<thead>
<tr>
<th>Age</th>
<th>Absolute Frequency</th>
<th>Cumulative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>68</td>
<td>1</td>
<td>3</td>
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<td>69</td>
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<td>4</td>
<td>27</td>
</tr>
<tr>
<td>87</td>
<td>1</td>
<td>28</td>
</tr>
</tbody>
</table>
**Figure 2**
*Age Groups of Subjects (N=28)*

**Gender, Marital Status, and Living Arrangements**

As expected, the women (23) outnumbered the men (5), 80% and 20% respectively. Figure 3 reflects the marital status of the subjects. Forty percent of the sample were widowed, 50% were married, and the remaining 10% were single and separated. Forty-four percent of subjects lived alone, and 56% lived with one or more family members.

**Income**

The data on income level was collapsed for coding purposes. Figure 4 illustrates income levels ranging from $5,000 to $30,000 per annum. One subject (3.6%) claimed less than $5,000 a year (lived with spouse), and one subject (3.6%) received more than $30,000 in annual income. Four subjects (14.3%) had incomes of $5,000 to $7,499. Approximately 40% of the sample (11) received $7,500 to $9,999 annually. Three people (10.71%) received $10,000 to $14,999 annually, while approximately 14.3% of subjects had annual incomes of $15,000 to $19,999. Four subjects (14.3%) reported $20,000 to $29,999 per year.
Figure 3
Marital Status of Subjects (N=28)

Figure 4
Income Level of Subjects (N=28)
**Education**

The education levels of subjects ranged from Grade 5 to Postsecondary education as Table 4 depicts, with frequency and percent. The histogram in Figure 5 illustrates respondent education levels by grade and percentage.

**Table 4**

Highest Education Level Reported (N=28)

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 5</td>
<td>3</td>
<td>10.7</td>
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<td>Grade 6</td>
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<td>Grade 8</td>
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<td>7.1</td>
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<td>Grade 10</td>
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<td>21.4</td>
</tr>
<tr>
<td>Grade 11</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Grade 12</td>
<td>7</td>
<td>25.1</td>
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<tr>
<td>Postsecondary</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>28</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Figure 5**

Education Level of Subjects (N=28)
**Race**

One Filipino female, two Iranians (married couple), and 25 male and female Caucasians were interviewed. Eighty-nine percent of the sample (89%) were Caucasians.

**Chronic Illness**

All subjects suffered from one or more chronic illnesses. The pie chart in Figure 6 illustrates the largest percentage (35.7%) of subjects (10) suffering from arthritis. Five of the respondents or 17.9% experienced cardiovascular conditions. Three subjects suffered from cancer (10.7%). Almost eighteen percent (17.9%) or 5 subjects suffered from osteoporosis, while 4 subjects (14.2%) experienced osteoarthritis. One of the subjects (3.6%) suffered from respiratory disease (emphysema). The largest portion of subjects, 67.8% or 19 out of 28 subjects, suffered from bone and joint diseases which resulted in physical and functional disabilities and the need for homemaking support. This large percentage of bone and joint disease sufferers consisted solely of women.
Care Levels of Subjects

Reports of the levels of care by age, gender and marital status of respondents are depicted in Table 5. Age range of males was between 65 and 89. Male subjects in this study were married. Two subjects between ages 70 to 74 were levelled at PC (Personal Care), and one male was receiving care at the IC2 level (Intermediate Care 2). One male subject in the 75 to 79 year old age range was levelled at IC 1, and one male in the 80 to 84 year old range was also IC1.

The females in this study varied in terms of marital status. Nine subjects were married: three in age groups 65 to 69 were levelled PC (Personal Care), and one widow at IC1. Age group 70 to 74 reveals two PC, one IC1, two IC2 in the married group, two PC in the widowed group, and one IC2 in the single group. Age group 75 to 79 shows one PC married subject, one PC widowed subject, and one PC separated female. The 80 to 84 age group illustrates one widowed PC and 6 widowed females at the IC1 level. The 85 to 89 age range reveals one widowed PC subject.

Table 6 summarizes the personal characteristics, and percentages of such characteristics, of the respondents in this study.

Table 5
Levels of Care by Age, Gender and Marital Status (N=28)

<table>
<thead>
<tr>
<th>Age - Males</th>
<th>Married</th>
<th>Widowed</th>
<th>Single</th>
<th>Separated</th>
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</thead>
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<td>Care Levels</td>
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<td>IC1</td>
<td>IC2</td>
<td>PC</td>
</tr>
<tr>
<td>65 - 69</td>
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</tr>
<tr>
<td>70 - 74</td>
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<tr>
<td>75 - 79</td>
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<td></td>
</tr>
<tr>
<td>80 - 84</td>
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</tr>
<tr>
<td>85 - 89</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Age - Females</th>
<th>Married</th>
<th>Widowed</th>
<th>Single</th>
<th>Separated</th>
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<tr>
<td>Care Levels</td>
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<td>65 - 69</td>
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<td>70 - 74</td>
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<tr>
<td>80 - 84</td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
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<tr>
<td>85 - 89</td>
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Table 6
Personal Characteristics of Respondents (N=28)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Female</td>
<td>23</td>
<td>80.0</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>20.0</td>
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<tr>
<td><strong>Age</strong></td>
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<tr>
<td>65 - 69</td>
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<td>70 - 74</td>
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<td>39.3</td>
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<tr>
<td>75 - 79</td>
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<td>80 - 84</td>
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<td>28.5</td>
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<td>85 - 89</td>
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<td>3.6</td>
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<td><strong>Marital Status</strong></td>
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<tr>
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<tr>
<td>Separated</td>
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<td><strong>Living Arrangements</strong></td>
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<td>Live Alone</td>
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<td>Not Alone</td>
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<td><strong>Education</strong></td>
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<td>Grade 12</td>
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<tr>
<td>Postsecondary</td>
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<tr>
<td><strong>Race</strong></td>
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<td>Caucasian</td>
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<td>89.3</td>
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<td>Cardiovascular</td>
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<tr>
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<td>10.7</td>
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<td>14.3</td>
</tr>
<tr>
<td>Respiratory</td>
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<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>100</td>
</tr>
</tbody>
</table>
FINDINGS

Perceived Well-Being Scores

The independent variable is homemaking services and the dependent variable is perceived well-being. A two-tailed probability evaluation with an alpha setting of 0.05 was deemed appropriate for this study. The non-directional hypothesis states: homemaking affects established measures of perceived well-being. The null hypothesis states: homemaking has no effect on established measures of perceived well-being. Data processing and statistical computations used the SPSS/PC+ software. Results were analyzed for statistical significance using the non-parametric Wilcoxin Sign Test. Appendix E displays a copy of the PWB Scale -Revised, while Appendix F illustrates the scoring instructions for the Perceived Well-Being Scale - REVISED (PWB-R) (Reker and Wong, 1984).

Table 7 illustrates the final results of the repeated measures Perceived General Well-Being test. A baseline score was recorded before subjects received homemaking services, in the three categories of psychological, physical, and general well-being. Six homemaking visits later, subjects were administered the PWB Scale and scores were recorded at Test 2, designated After in Table 7. Differences in scores are indicated between

<table>
<thead>
<tr>
<th>Homemaking Services</th>
<th>Mean Psych Score</th>
<th>Mean Physical Score</th>
<th>Mean GWB Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>44.400</td>
<td>24.967</td>
<td>69.367</td>
</tr>
<tr>
<td>After</td>
<td>47.571</td>
<td>29.464</td>
<td>77.035</td>
</tr>
</tbody>
</table>

Psych 1 with Psych 2

Z = - 3.2826
2-tailed P = < .0010

Phys 1 with Phys 2

Z = - 3.3738
2-tailed P = < .0004

GWB1 with GWB2

Z = - 3.8320
2-tailed P = < .0001

Conclusion: Using alpha p = < .05 2-tail, since T obt < T crit, Ho rejected.
psychological, physical, and general well-being. Mean psychological well-being score before homemaking was 44.400, and after homemaking the mean score was 47.571. Mean physical well-being scores before homemaking were 24.967, and 6 homemaking visits after, the mean score was 29.464. The overall general well-being score (combination of psychological and physical well-being) was 69.367 before homemaking started, and 77.035 6 visits later. Because the investigator chose alpha .05 (5 chances out of 100 the relationship is the result of chance) as the cutoff point to separate findings that are not considered significant from those that are, we must conclude from the 2-tailed probabilities listed in Table 6 that these results are statistically significant and the null hypothesis: homemaking has no effect on established measures of perceived well-being, is rejected.

Results are positively and statistically significant at the 5% level. Figure 7 represents the before/after scores of respondents' psychological well-being. Figure 8 represents physical well-being scores at Test 1 and Test 2. The combination of psychological and physical well-being are represented in the overall general well-being scores of subjects, before and after 6 homemaking visits, in Figure 9.

Figure 7
Psychological Well-Being Scores Before and After Homemaking Services (N=28)
Figure 8
Physical Well-Being Scores Before and After Homemaking Services (N=28)

Figure 9
General Well-Being Scores Before and After Homemaking Services (N=28)
Highest General Well-being Scores

The average difference in General Well-Being Score of all subjects between pre and posttest was 7.1 points. Three subjects had decreases in scores and one had no change. All other scores have increases at posttest between 1 and 24 points, as Table 8 illustrates.

The highest GWB score at both pre and posttest was obtained by a 70 year old, married, Caucasian female who lived with her spouse. Prior to Time 1 she suffered a heart

<table>
<thead>
<tr>
<th>Subject #</th>
<th>Pretest Score</th>
<th>Posttest Score</th>
<th>Change in Score</th>
</tr>
</thead>
<tbody>
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<td>54</td>
<td>78</td>
<td>24</td>
</tr>
<tr>
<td>17</td>
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<tr>
<td>4</td>
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* 7.1 = Average Change in Score
attack, and her husband suffered several heart attacks, open-heart surgeries and a stroke prior to homemaking services. Combined family income was in the $20,000 to $29,999 range. Her pretest GWB score was 93, and her posttest score was 98 out of a possible 112.

Another married, white 65 year old female who lived with her spouse obtained high GWB scores at pre and posttest (88 and 95 out of 112). This lady also suffered a heart attack and her spouse's health was very tenuous at best. Her income range was below $5,000, however combined family income was in the $10,000 to $14,999 range.

The third highest GWB pre and posttest score was obtained by an 84 year old married white male who lived alone, and he experienced a lot of emotional support from a large family, particularly from his eldest 60 year old daughter who brought him meals each day. His wife had dementia and he visited her each day in the nursing home. His average income was in the $20,000 to $29,999 range. His illnesses included arthritis and blindness in one eye. His scores pre and posttest were 83 and 91 out of 112 respectively.

**Lowest General Well-being Scores**

The lowest pre and posttest GWB scores were obtained by an 81 year old Caucasian widow with multiple health problems. Annual income was between $20,000 and $29,999 and she lived alone. She had a daughter and family in Vancouver who kept in touch by telephone daily. Table 8 illustrates her pretest score of 48, posttest score of 43 out of a possible 112; and decrease in score of 5 points. Possible reasons for this decrease in perceived well-being was her anxiety around the bad news she received about her health. She appeared to be very depressed and worried about some diagnostic tests she was to undergo. Her illnesses include cancer, asthma, kidney problems, and gallstones.

The next lowest score in GWB was obtained by an 84 year old Caucasian widow who suffered from a heart condition. She lived alone and had no family or friends to rely upon for support. She appeared to be depressed although was not diagnosed as clinically depressed by her physician. She was very anxious and afraid. Her income range was $20,000 to $29,999. Her pre test score was 51 out of a possible 112. Posttest was 64/112.
A white married 69 year old female who lived with her spouse had a score of 52 at pretest and 68 at posttest. Her spouse had recently suffered a CVA. Income range was $20,000 to $29,999 combined. She claimed to be in a “dysfunctional” marriage, and had very strained relationships with her two sons and their families. She appeared depressed although had never been diagnosed by a physician as such.

For the total sample, lowest scores pre and posttest were obtained by widows, but not necessarily those in lower income brackets, as much of the research reports (Aronson, 1989; Harris, 1978; Herzog and Rodgers, 1981; Kasl and Berkman, 1981). Widows in this low score bracket reported higher incomes than most in this category ($20,000 to $29,999).

**Greatest Decrease in Score at Posttest**

The greatest decrease in posttest score of GWB was obtained by a married white bed-ridden 73 year old female, who suffered from severe emphysema. She lived with her supportive spouse, and had a very supportive family, but her health deteriorated in the 6 weeks and her overall score of 76 decrease by 8 points (Table 8).

A widowed white 68 year old female, living alone, who had terminal cancer, showed no change in score at posttest. (Test 1 and 2 = 73/112). Her cancer was causing her considerably more pain and difficulties in managing activities of daily living. Although she expressed her appreciation of the homemaking, her spirits were being negatively affected by her deteriorating health. Her income range was $20,000 to $29,999.

**Greatest Improvement in GWB Score**

Two widows achieved the greatest improvement in overall GWB scores. The first was an 80 year old in the $20,000 to $29,999 income range who lived alone. She had suffered a heart attack prior to homemaking and had no children or relatives to turn to for support. She was very anxious and frightened at the pretest assessment interview, and
item number 2 of the PWB Scale - “No one really cares whether I’m dead or alive”, provoked tears, as she responded undecided. Further, statement number 8 - “Sometimes I wish I never wake up” provoked a tearful episode, and she responded moderately agree to this item. These responses suggest depression, according to Reker and Wong (1984). Her pretest score was 54 and her posttest score was 78 of a possible 112 points; an increase of 24 points (Table 8). She enjoyed the homemaking and was thankful for it, and felt good enough psychologically (less depression, less fear, less lonely) and physically (more energy) at posttest to cancel the service.

The second subject with the greatest improvement in score was an 80 year old widow who lived with her only daughter and her family. She scored 70 at pre test and 91 on the posttest: an increase of 21 points. This lady suffered from severe emphysema and osteoporosis, and was in the annual income range of $7,500 to $9,999. At pretest she had recently been discharged from the intensive care unit after having suffered from a severe bout of pneumonia. This had been the ninth hospital admission and discharge in 3 months. She had been very near death and her status at Test 1 was tenuous at best. She was bored and spent her days and nights watching television, while her daughter slept all day and worked nights. She was also discouraged about the lifestyles of her daughter and children and grandchildren. She agreed strongly to the statement “I am afraid of many things” on both tests, qualifying her fear as that of death. She strongly agreed that she was bored. However, the of particular interest was her response to item number 9 “I am in good shape physically”. At pretest she responded with a definite “disagree”, and at posttest she responded with a definite “agree”. She clearly felt better at Test 2 and this may have been because she was perceiving her health status to be improved. She had no hospital admission during the interval between Time 1 and Time 2.

**Outstanding Changes in Response**

Responses to item #15 (PWB Scale) “I have peace of mind” were particularly interesting in that the differences in responses between Time 1 and Time 2 were so great.
Figure 10 illustrates the responses graphically. It appears that peace of mind of most subjects improved at Time 2 after the 6 homemaking visits. About 85% of respondents agreed that they had peace of mind at Time 2, while during the baseline recording, only about 17% agreed they had peace of mind.

**Figure 10**
Response to Statement: "I have peace of mind" (N=28)

![Graph showing responses](image)

Responses to Statement—From strongly agree to strongly disagree

Figure 11 illustrates the graphic response to the statement, “I am in good shape physically”. Another dramatic difference between Time 1 and Time 2 occurred. At Time 2 there were 19 positive responses to this statement (68%), as opposed to 9 positive responses (32%) at Time 1.

Statement 7 on the PWB Scale - “It’s exciting to be alive” provoked the consternation of many subjects. This statement was designed by Reker and Wong (1984) as measurement of psychological well-being, and the presence or absence of depression. Twenty-three (82%) respondents suggested to the writer that the word *exciting* was an inappropriate word to describe their lives at this time. They felt that life was no longer exciting for them, but agreed that the words *satisfactory, adequate*, or *suitable* might best describe life as they know it today. Seventy percent of the sample agreed that life was exciting, in spite of the wording, and at posttest, 78.6% of the sample agreed that life was exciting.
Only two subjects felt life was not exciting; one was a 72 year old male who tried to commit suicide several times, and was deleted from the study, and an 80 year old widow who disagreed at Time 1, but 6 weeks later, she strongly agreed that life was exciting.

This lady made a remarkable recovery in her outlook on life, psychologically and physically. She was very depressed, although not clinically so, at Time 1. She had no family or friends, and was completely isolated, partly because of her inability to ambulate without a walker as a consequence of severe arthritis. Her homemaker took her over to another CCD client in the same building and introduced the two ladies when she saw how depressed and lonely this subject was. When the researcher arrived at her apartment to administer Time 2, she was greeted at the door by the subject, who was having a “tea party” with six other ladies. These ladies had involved the subject in bowling, and church activities, and one might presume this to be a success story that we can attribute to the wise homemaker who introduced this lonely lady to others in the apartment complex.
EMERGING THEMES FROM QUALITATIVE DATA

Following are the five themes which emerged from the 4 qualitative questions:

1. perceptions of own health
2. opinions about the homemaking service
3. relationships between gender identity, roles, and housekeeping values
4. perceptions of the homemakers
5. lack of continuity in the service

Perceptions of Own Health

Although question number one: What if any significant changes have taken place in your life over the past 6 (8 or 10) weeks? was asked with a view to obtaining information about significant changes in subjects' lives during the 6, 8 or 10 weeks of homemaking in order to control for extraneous variables, the concepts and themes which emerged from this inquiry resulted in descriptions of perceived health both before and after homemaking.

Direction and focusing of the question by the interviewer ascertained whether any significant life changes which may have confounded the results, but the direction of responses invariably ended up with the descriptions, seen below, of how the respondents felt physically before and after the homemaking services began. Therefore, in this primary analysis, "perceptions of own health" is taken as their key response to the first question.

In terms of client need as a result of chronic conditions, ill health and decreased functioning, the respondents in this study were at considerable functional, social, and economic disadvantage compared to seniors who do not qualify for homemaking. Fifty percent had no immediate family, and few acquaintances with whom who they could have regular contact. Economically many of their annual incomes reflected the poverty
level, and objective health measures indicated a bleak future for many of these elderly people. At the time of the initial assessment they were clearly in need, having been referred by their physicians and/or hospital nurses and/or social workers. Health issues seemed to be foremost in their minds. Fifteen subjects were aware of their failing health, had limited knowledge of their diagnosed illness and experienced diminished function and mobility as is illustrated in the recorded posttest interview response to question 1:

Before I started the homemaking my doctor said I was sick, I knew I wasn’t feeling good, thought it was the flu. I couldn’t move. I couldn’t get out of the bathtub. I didn’t have a bath for three weeks because I couldn’t face getting in and out of the tub.

An 84 year old male respondent when asked about significant changes in his life at Time 2 digressed and told me about his vulnerability and diminished function resulting from his failing health:

Because of my health and I couldn’t ... I was ... my wife was gone, and she left me, and I couldn’t see, my eyesight isn’t that good anymore and I can’t see very much. You see I can’t get around like I used to in the good old days (laughs). I guess my health is failing me. You know, my ... and that is the reason that I got a homemaker.

The theme of anxiety is depicted below. This 79 year old widow was unaware of the severity of her problems. She was to be admitted into hospital shortly after this interview took place because her physician suspected lung cancer. She suffered from emphysema and arthritis but did not seem to understand the implications or the extent of her poor health:

Yeah, I was feeling not good, but I didn’t know. I didn’t know I was that sick, I was really sick, I guess and I didn’t know that. My doctor just phoned me one day and tell me I’m gonna get some help because he say I need somebody to help me and come in and check up on me (laughs).

Twenty-one percent of the sample met the criteria for high risk, or vulnerable elderly who are at risk for institutionalization: unmarried, female, living alone, on low incomes. Their needs are a result of physical decline and chronic health conditions. Problems in ambulating and decreased mobility were particularly prevalent, however, it
frequently seemed that those who were most at risk were the ones who denied poor health and claimed that they didn’t really need any help (6 subjects). One 80 year old lady who, although she displayed enthusiasm for the research project and agreed to participate in the study, appeared mildly agitated and resistant to the idea of receiving assistance from homemaking even though her health was clearly compromised.

The following respondent had been assessed to receive service, because of the concerns of her doctor and her son, and did, in fact accept the homemaking service, but she expressed the need to impress upon the writer that she was still in control and found difficulty in adapting to this new lifestyle which was thrust upon her. Although she agreed to participate in the present study, and had completed phase 2, she still presented in a defensive mood. The following excerpt of the transcript depicts the way she portrayed herself even after services. The themes vulnerability, and decreased sense of self-esteem seem to show through her anger in the excerpt below:

I don’t know why you’re around bothering me. Are you writing some kinda book about me or somethin’? I’m okay you know. Who said I was sick anyways? Some dumb doctor? What d’you expect? What do they know? They know nothin’. A bunch of quacks! I didn’t ask for nobody to come around to bother me you know, my son wanted all this, and now have to put up with some girl I don’t know coming in here every week and bothering me.

Eleven (39.2%) subjects seemed to accept their deterioration and did not wish to burden others with their concerns. In the excerpt below I did sense a decrease in anxiety, which may have resulted from a reassurance from her physician:

Well, you know I just thought I’m getting old and decrepit and this is just one of these things I have to live with. This is old age, but then Mrs. I told me to go to me doctor because I could hardly move, and I started to get scared and wondered is this really age? Turns out it wasn’t just age but something else, but I feel better now because he (the Doctor) put a name on it. I had the pain but I didn’t want to talk about it, but now I can talk about it because it has a name and I’m not just crazy. By the way dearie, don’t let anybody fool you about the golden years, what’s so good about being old?

The theme of diminished function/mobility is depicted in the following excerpt. Becoming sick frequently evoked feelings of humiliation as Mrs. ______, an 82 year old
spinster and former accountant, and Mr. ___, an 84 year old so painfully relate:

Oh it's terrible, I just never thought I'd ever um, well who would think that an old lady like me would wet my bed? I sometimes think, oh this just can't be happening to me, you know, I never thought it would ever happen to me. You just never know, and it's so embarrassing to have the girls have to wash my sheets when I wet the bed.

Well, I just find it embarrassing to ask for help... you know I was a businessman and ran my own meat outlet, and you just go by from day to day and never think it will ever happen to you, and bingo, you've been reduced to a crippled-up old crock like me and your pride goes out the door!

Perceptions of health, however, did take on a more positive light. *Improved self-perception* and *improved health perception* are illustrated by subjects, who appeared less anxious after homemaking services:

Well, I still have aches and my hands get bad at times, but it's so good to feel I don't have to do it (work) when I'm feeling so bad. That little girl coming in here, just gives me extra energy and the peace of mind knowing that my house is in order. You actually do feel better, but it's probably all up here (points to her head).

Yes, yes I do feel much better since C____ has started to come in, I mean well, who's to say, maybe it's all in my head that I feel better, but I feel good when I know when she comes in, that for the next two weeks the house is going to be clean and that makes me feel better somehow.

Although the objective health measures may not have changed, it appears that it is the subjective assessment of one's health status (*improved health perception*) that enables the individual to function more independently and effectively:

Well, the help I get takes my mind off my problems, I mean that I really think it's your mind. Sure I know I have problems but when S______ comes I know the work it getting done, and I feel more rested so it gives me a chance to do the other things that piled up. Your body works if your mind's willing and you can overcome a lot of things if you're happy in here (points to her head), at least if you're feeling more at ease about things. I can walk to the store now, and pick up things I need, and I know I don't have to go back to a pile of stuff I couldn't do, cause S____ does it all now.

All respondents, except for one lady, felt they were feeling better physically after the homemaking service was in place. Twenty-one subjects (75%) acknowledged that they
were feeling better physically, and 24 (85%) acknowledged feeling better mentally; these acknowledgments were confirmed by changes in PWB scores. The homemaking assistance may have provided them with more peace of mind, an increased sense of control, a the perception of feeling better as a result.

Opinions of the Homemaking Service

The homemaking service is part of the independent variable and opinions about this service are crucial to the exploratory part of this research.

It is important to understand the complexity of the homemaker/client relationship. Two people come in contact who have never met before, and the homemaker is expected to work in a home she is not familiar with, for a person she doesn’t know, with no supervision, no co-workers to talk to, and no structure to adhere to. She arrives at the doorstep of the client with a list of tasks she/he is to carry out, which have been dictated by a Case Co-ordinator of Continuing Care.

For the home care client, the sanctuary of home suddenly is subject to outside and unfamiliar forces. For the elderly lady, her home has been her domain for years; the one place where she experienced control, comfort, familiarity and self-worth. Suddenly a stranger comes to her door and she is expected to allow her in to touch and clean her personal possessions, even her body. Two complete strangers suddenly become involved in intimate activities.

In response to question 2, What is your opinion of the homemaking service? the theme of criticism is illustrated in the following excerpt. Mrs. ____, a 65 year old house-proud lady, was critical initially as she discussed the homemaking service:

No, I didn’t want her in here at first. One reason because she smelled like smoke, but what can you do? That’s who they sent. I didn’t like it because when she left, the house smelled like smoke, even my closets smelled like smoke. I don’t even know her . . . are they bonded? I mean I don’t want to sound like complaining, but how do you feel if a stranger comes in your house?
Fifty-three percent of the sample became comfortable with the intrusion and were glad to have the help. There were mixed reviews, however, about the quality service itself, and the themes of disappointment and criticism are revealed below:

Well, she didn’t do what I wanted her to do. I mean all I got was a lick and a promise. She didn’t even get up on a chair and clean the top of the china cabinet. She said she wasn’t allowed to . . . what kind of maid service is this?

The idea of strangers intruding and touching cherished, precious belongings was difficult for 25% of subjects to come to terms with, as is demonstrated by the following comments from an 80 year old apartment-bound widow, who suffered from severe osteoporosis. The theme of loss of control as a result of intrusion is depicted below:

I hope they know not to touch some things in here. Are they trained like that? I don’t want anybody to touch my mother’s vase. You know that vase (points to it) is over 200 years old, she got it from her mother, and nobody touches it. (I walked towards the priceless article to have a better look at it and the subject shouted at me) Don’t you touch it either!

Fifty-three percent (15) respondents expressed feelings of relief at having someone help them even if it was a stranger, especially subjects whose income levels were in the very low ranges. These seemed to be the people who appreciated the service the most:

I don’t care who they send, as long as I get help. I can’t stand to sit in here anymore it’s such a mess and I’m too sick to anything about it. Anybody could come and I would be happy.

Oh no it didn’t bother me a bit when she came. I was glad to have some help, any help would do. We’re so lucky to have this when we get old and sick, oh no, I can’t say I was worried about the girl coming in, I was glad.

It appeared that the larger the subject’s income, the less satisfaction with the service. Clients are asked to declare income at assessment, because services are pro-rated on income. Perhaps because of this fee for service, the client’s expectation was greater. The theme of disappointment emerged as a result. The number of hours clients were allocated for homemaking was of concern to some, particularly those with a fee. The following subject felt that “a proper cleaning” could not be performed in the amount of time given.
Also because she paid a portion of the cost of the service, she felt somewhat cheated that a 2 hour cleaning period was reduced to 1 hour and 45 minutes because the homemaker required travelling time to get to the next appointment:

I pay for two hours and she leaves here 15 minutes early every time. And this last time I asked her to clean the chandelier and she said she wasn’t allowed. She forgot to dust the baseboard too. I pay $7.31 a week, I mean what am I paying her for if the work doesn’t get done?

In spite of the fact that clients are told not to expect a professional cleaning service and that homemaking is part of a Continuing Care Program to maintain clients in the community and provide a healthy safe environment by the provision of certain services, subject expectation was often high and criticism of the service was forthcoming:

Well, she did everything but——she do it, but uh, you know, she really did nothin’, and the second time she came I laid down because I had just come from the doctor, and I fell asleep right away. She did almost nothin’! You know, do I have to go behind the woman and say do this, do that? The problem is I need the help, and I’m glad of it, but I wish they could be more fussy.

The unexpected theme of value of housekeeping in response to question 2: What is your opinion of the homemaking service? is expressed by an 80 year old lady with severe osteoporosis illustrates this point:

I like to have my kitchen floor done with hot soapy water first, and then I usually dry it off with a cloth and then put the wax on with a clean cloth. But she doesn’t do that, she just sort of pushes around a damp BeeMop, here and there, she’d just push it around and then tell me she’s finished. That’s not what I’d call cleaning. You’d think they’d train them right. I mean what’s the sense in paying for it if you don’t get it mopped right?

Others perceived the service to be a “wonderful thing” and the theme of satisfaction emerges in the following excerpt of an 84 year old man whose wife was in a nursing home:

Oh, it’s great. Well, she …the homemaker comes in and does what work, I mean the kind of work that I would never think of. A woman would I guess. You know, think of doing all this stuff that she is doing. You know, I would never think of it. I used to dust . . . this half of it, of course, but when the homemaker comes in the . . . well, when she goes out this place is spotless!
The responses generally were very positive, however, one angry deficit-conscious subject's response is an example of the theme decrease in self concept. She felt the service was a complete waste of government money. However, this statement may have been in response to her loss of independence and autonomy:

No I don't want it (the service) anymore. It's a waste of government money. The young people have to pay for it, it just turns me sick! I mean what are we doing squandering money like this, when we're so much in debt? What about the young people today? How can they pay for all this? I've never asked for help before and I'm not an abuser of the system like so many of them. You know you should check it out. I know people in here who get a maid just because somebody told them to get their doctor to call you guys. Everybody rips off the system. I think it's disgusting!

The declaration above comes from an 80 year old lady who was very ill and in need of service. This widow lost her husband 30 years previously, and she reportedly worked hard all her life (independent and autonomous). She is a proud lady who watched television all day, and read the newspapers, and exhibited remarkable knowledge and concern about our economic condition in Canada. Her doctor phoned a referral for help because of her multiple serious health problems, but during the posttest she informed me she no longer wanted the service and would be cancelling it when she was finished with the diagnostic tests at the hospital in the following week.

An important consideration when considering perceptions of homemaking services is the feeling of loss of control and independence that occurs as a result of receiving such assistance. Twenty respondents (71%) bemoaned such losses; even though they expressed and acknowledged the value of the homemaking service. It represented, at least in their minds, one step closer to institutionalization. Having to relinquish independence can be an important issue in dealing with the service itself as Mrs. B_______ relates:

I find it degrading to ask for services, but what can I do? I can barely get around anymore. I know I should be thankful for what I get and I am thankful, I need the help, but I wonder what the next step will be? What happens to me when this isn't enough?

One female subject clearly required the assistance of homemaking, but unfortunately did not feel good about the homemaker being in her home. This 72 year old lady had been
a widow for 45 years and was extremely independent, proud, and meticulous about her home and possessions. Diminished health had caused her to rely upon external help. Her statement seems to exemplify her grief over lost independence and autonomy and resulting decreased self concept, even though she acknowledged the usefulness of the service:

You know, I probably shouldn’t say this to you, especially, but I just wish I didn’t have to have her (homemaker), I wish I didn’t need anybody’s help. I actually hate it when her day comes round and I say to myself, oh, no, she’s coming again tomorrow. I can’t even go out when she’s here, so I have to go sit in another room. It’s so humiliating to ask for help, especially if you’re like me. You know I raised 3 kids and worked two full-time jobs all by myself, and I travelled later, and lived in a cute little house I bought myself in Kerrisdale. And now look at me!

To summarize, 23 of the 28 (82%) subjects expressed satisfaction with the service itself, in spite of the negative comments illustrated in this chapter, which were mainly related to subjects’ fears and concerns about their status in life at this time. Between the time span of this repeated measures design, it appeared that relationships emerged which became quite significant to subjects, and possibly to the homemakers. The following theme, which came out of question 2: What is your opinion of the homemaking service? illustrates the importance of the role of housewife and housecleaning.

**Relationship between Gender, Identity, Roles and Housekeeping Values**

The role of homemaker/housewife was of apparent importance to these elderly women. Comments about the importance of being a housekeeper, and the identity as a result of women’s roles in the home, emerged as subjects responded to question 2. All the women in the sample except three (one separated one widowed and one single woman) saw themselves as good housewives who take their role seriously:

Listen, this is what I do, I cook, I clean, I bake. We were raised to look after husbands, babies and the house, and I’ve always been a good homemaker to my family.

I worked my fingers to the bone for that man, because I thought
that's what true love is, you serve your husband because you should be thankful that you got one. Don't ever let your man down my mother said, and that means keep him happy, keep his house clean and if you want to stay in his favour never let him get hungry.

Even when women no longer have husbands to care for as a result of death, divorce and/or separation, the salience of the homemaker role and sense of identity still persists:

Now that H___ is gone and I'm not a housewife anymore, I still do what I have to do around here, because that's what I do, I'm still a homemaker.

For this cohort of women, husbands were viewed as the "provider" while the woman's identity was generally confined to the home. Women viewed themselves and were often judged by others in terms of the kind of home they "kept", the whiteness of the clothes on the line, and whether they made their cakes from "scratch". To be seen by other housewives, friends and relatives as a good homemaker was to be highly valued, and most women took great pride in how good others judged them to be. The following excerpts illustrate the themes of sense of identity and gender roles:

Ah, I've always been a homemaker you know, I've always done my own work, and I've never had any help even when I was sick with my babies. I mean, I just did everything. I used to bake my own bread, I baked all the time, but of course, I can't do that now. It bothers me now, because I would like to be able to do all the stuff myself.

Well, I just like to keep a clean place, and looked after my family. It's a pleasure to look back at all you have accomplished. It gives you something to be proud of.

Following are examples of the theme learned behaviour. Many women seemed to have been conditioned in homemaking by their mothers:

Mother was clean, and we were poor, but you know we always had clean white clothes to wear on Sunday. She never believed in dirty grummy clothes. She always believed on Sunday we had nice, well she always said your clothes could be old and patched, but at least they're clean.

Cleaning was what we were brought up with. On Saturday I had to clean the stairs, and my sister had to clean the bathroom. My father wouldn't put up with anything less. He wanted his house
clean. We all had chores to do in the house, and my mother would give the one that did the best job a special treat.

An excellent example of the theme gender roles comes from this 80 year old lady who shared with me a special little ditty with me that she remembered her grandmother reciting to her:

"G___ is her name, single is her station, Lord help the man that makes the alteration" (laughs).

My mother and grandmother used to say that little ditty to me and told me “God help the poor man that gets you!” Another thing my mother always said to me is the way to a man’s heart was through his stomach, so you better learn how to cook now. I was cooking supper every night for my mother and father and sisters, when I was nine. My mother always told me that a man’s home is his castle and if I wanted to be a good wife, I had to keep it clean and make him proud. I always kept a nice house for my husband, he could bring anybody from work home, my house was so clean.

For those who have friends and social support, the value of housekeeping, a theme emerging from the second question, seems paramount. Hostessing is not taken lightly because it is still seen as an opportunity to display housekeeping and homemaking skills to peers:

I don’t have that many friends anymore, they all died, but I do see a few every other week and we have tea and sometimes play cards. I like the company and I like to have the place presentable when they come. I wish I could still bake, I was a great cook, my husband used to tell me, but I can’t stand for long periods of time at the sink so I have to buy cookies and cakes when they come, and it’s not the same.

Most respondents valued women’s work highly, even though it may still not be highly appraised by society as a whole. These elderly ladies derived such a great amount of pride and a sense of identity from knowing that others knew how competent they were:

I always was a good cook, and all my friends knew it too.

I won ribbons at the blueberry pie contest eight years in a row, there wasn’t another woman around that could come close to my pies.

The other women used to ask me the secret of my white sheets. Nobody knew how I got my sheets so white. I used to just love to
hang them out then wait for everybody to come around and ask me how I got them so white. And I wouldn't give away that secret ever.

We never had money, or good clothes, but my kids always looked good when we took them out. People used to stop us on the street and say what lovely kids they are, and oh my, how well-dressed they always are. I could patch up old clothes like nobody and make them look good. I can still do it today, I bought this material for $1.89, just a remnant, but look what I can do with it, (displays her blouse for me) I can make anything look good. You had to in those days, you had no money.

Twenty women in this sample of twenty-eight (71%) extolled upon the virtues and value of housekeeping and homemaking. The five who did not were males, and of the three remaining ladies who did not shout the praises of good housekeeping, two were acutely ill and dying and possibly homemaking ceased to be of importance. The only subject who did not elaborate upon the virtues of housekeeping was the lady who seemed to be consumed by concern about Canada's deficit, and she was focused on her own serious health concerns.

**Perceptions of the Homemaker**

When asked: *How do you view your homemaker?* at posttest (question 3) the homemakers were labelled as “the girl”, “the maid”, “a good friend”, “my girl”, “the worker”, and occasionally “an employee”. Homemakers frequently were the only social contact five clients had from week to week. As previously mentioned, 50% of subjects had no family or friends. All of these subjects became very attached to their workers. Mr. K who is 84 years old, looked forward every week to his homemaker visit as is shown in the example below. This statement clearly illustrates the themes *client feelings* and *homemaker qualities* which emerged from responses to question 3:

How do I see her? Oh really great! She’s so bright and cheery. She’s somebody I can talk to. She’s very good that way. She’s a real friend. She tells me about her kids, and I feel like I’m part of the family.
A married couple in their 70’s, who both suffered from complications of cardiovascular disease, expressed their delight and their feelings about their “little girl”:

Oh, she’s a real gem, a godsend! We see her as our friend, not as somebody we hired. Let’s say we consider her as an aid, to help us in the support that we really need to have in the house. She’s such a cheery little girl, I don’t know how I got along without her. My husband says, oh what a lovely job that little girl did last week, the place just shines, and oh what a job P did doing this, and doesn’t she do that good . . .

Social and emotional support from another human being and the theme of client feelings are reflected in the following comment from a 78 year old separated arthritic lady, who lives alone in a two-room basement suite in the house of an Asian family:

Well, she’s somebody who’s really doing me a favour because I hate housework (laughs). No really, I don’t get to see people very often and when E comes it’s like a friend dropping over. She must really like old people, because she’s always nice to me and she tells me about her kids, and what she’s doing on the weekend. She’s more than just a help to me, she’s like a friend. And she’s not embarrassed to do anything. I had a thing here (points to her buttocks) and I couldn’t really see it, but it hurt, and E comes in and I tell her and she says well let me see it, maybe I can help you. So there I am, old flabby me, I pull down my pants and E looks at it without even hesitating, like she’s seen old ladies back ends all her life! Only a good friend would do that, eh?

A comment from an 87 year old lady who lives in a seniors complex, and seems to have lost just about all her friends because she outlived them all illustrates her feelings and the significance of someone to talk to:

It’s gotten so lonely and quiet around here now . . . Mr. died last week and it seems like everyone’s gone now, so it’s really nice when F comes to clean the house. I have someone to talk to, but she works too, she just doesn’t talk! Sometime if she finishes early I give her a glass of juice, and she sits and talks to me. She brought me some flowers and a card on my birthday . . . the only flowers I got. Sometimes she hugs me.

A married couple, who are both 78 years of age, severely crippled with rheumatoid arthritis, and childless express their feelings about their homemaker:

(Mr. S) There’s nobody like her! C is a real princess. The other one was real sloppy but C, we just love her. She’s always laughing and joking. She makes me laugh too.
(Mrs. S) She's great. I wished we'd had her before. We work together and we talk all the time. She's a godsend. It's like having a girlfriend. We just hope we can keep her. I've got so used to her now.

The theme of homemaker qualities emerged from other subjects in this study:

I maybe shouldn't say this but the best thing with G___ is the companionship, I know you told me not to make her a coffee but I do that anyway, and we sit down and have a chat. She's nice to me and listens. That's important, and she does what needs done, that's important too.

She wears nice clothes, and she's always happy and she says how's this and how's that, and what can I do for you today, and how do you feel? It's nice to have someone that cares about you. She must like old people.

Not included in the task list is the emotional support provided by this homemaker:

Well, being cheery is a big help for me, I only wish I felt better when she was here, because I like her so much, and I feel bad when I'm not up to snuff, because she's always so bright and optimistic. She hugs me every time before she leaves.

The following interview sample illustrates the kind of caring and sensitivity subjects feel for their homemakers:

She knows me and I know her, and you sort of uh, get sort of attached to them you know. She was going to take my drapes down last week but I said no, you're too small and you might hurt yourself, I'll get my grandson to do it. I don't want you to hurt yourself, or they might send somebody else.

Twenty-six of the twenty-eight subjects (92%) in this study had positive remarks to share about their homemakers, despite the disappointment of five subjects in the quality of performance of housecleaning duties. One subject mentioned earlier felt the service was a waste of taxes and did not acknowledge any positive feelings she may have had about her worker. Another elderly subject just felt the worker was intrusive and although she acknowledged the importance and her need for help, she admitted that she did not look forward to her worker's weekly visits, and tried to make herself scarce each time.
Lack of Continuity in the Service

The most common themes to emerge in response to the question: Can you suggest ways of improving the service? was the frequent lack of continuity and feeling of being the passive recipient of services when homemakers' schedules were changed by agencies to accommodate other clients or emergencies. Twenty of the respondents were faced with permitting a different worker into his/her home and life often on different days than those scheduled. Following are two examples of the responses I received:

I liked the girl they sent me and I had her three times and one day they phone me and tell me they’re sending somebody else 'cause she (the homemaker) has been sent to another client. Why did they do that to me, why couldn't they just send the other woman somebody else? I was just getting used to T____.

It's frustrating, I just got to know C____ and she knew just how to do everything and where everything is, and then they stopped sending her, and when I phoned and asked about it they said, well, we had to send her somewhere else. I liked her and now I have to try to get to know a stranger.

None of the subjects mentioned race or the culture of their homemaker. Eighteen subjects felt that the quality of the cleaning should be uniform, because subjects discovered that different homemakers perform different tasks. For example, although shopping for clients is prohibited by homemakers as a result of Richmond Continuing Care policy, some homemakers continue to run shopping errands for their clients. Ironing, is another task which is prohibited however, I did receive some complaints from subjects whose "neighbour gets ironing, so why can’t I?" Subjects felt that everyone should be treated equally in this regard. With these exceptions, there were no other recommendations.
This study was undertaken to explore relationships between the formal support of homemaking services and measures of perceived well-being of twenty-eight community-dwelling senior recipients of such care.

The findings of the present study support the hypothesis of this study: established measures of perceived well-being in community-dwelling seniors were changed after the introduction of homemaking services. This has been supported by the objective measures of perceived well-being and by the subjective comments made by elderly informants about their homemakers during posttest interviews.

Elderly respondents perceive their homemakers as meeting many of their needs through the provision of emotional and social support. However, the instrumental support, that is to say, the support provided through the execution of the housekeeping chores that subjects can no longer carry out because of diminished function and deteriorating health, has proved to be significant, particularly to female subjects. The significance of the presumed emotional support subjects might receive from their homemakers was not directly expressed. The themes: perceptions of health, opinions of the homemaker and the homemaking service, gender identity and roles, values of housekeeping, and lack of continuity in service were expressed directly.

The sex ratio in this study is concurrent with current demographic trends which show an unequal distribution of aging males and females (McPherson, 1990). In other words females outnumber males as they age. Demographers suggest the current ratio is 75 males for every 100 females for those 65 and over, and for those aged 80 and above, the ratio decreases to 54:100 (Statistics Canada, 1985). The sex ratio of this study was approximately 30:100 which is much lower than the current figures. This most likely is a reflection of the convenience sampling procedure. The sample also consisted of an almost
50/50 split between married and widowed people. These findings are consistent with the demographic trends in Canada and North America today (Health and Welfare, Canada, 1990).

With regard to perceived well-being scores, the results of this study show little if any support for gender differences. One of the problems of course, is the small representation of males in the study, however, those men who did participate obtained similar scores to females. These data are supported by evidence from other studies that indicate that gender is a poor predictor of well-being (Medley, 1976; Diener, 1984; Wilson, 1967).

Age seemed to have little or no relationship to perceived well-being of subjects. Some of the highest general well-being scores in this study were achieved by those in their eighties and those in their mid sixties. Conversely, some of the lower general well-being scores were achieved by those in the same age groups previously mentioned. The author concurs with the literature that the age of an older adult is a poor predictor of general well-being. Research on age and well-being requires more longitudinal data before an accurate assessment of their relationship is possible. However, there have been suggestions that individuals' well-being remains stable over time, so if one is a happy-go-lucky young person, one will be a happy-go-lucky old person, and vice-versa, at least until the early 70's (Kozma et al., 1991).

Being married is related to measures of PWB in all age groups, according to researchers such as Diener (1984) and Larson et al. (1978). The current study reveals that the one common denominator in subjects with the highest PWB scores both pre and posttest is marriage. These findings concur with other similar results in the literature. Perhaps this is because being married enables spouses to experience more activity and interaction socially, than those who are unmarried, thus increasing perceptions of psychological and physical well-being. The married respondents in this study who lived together reported more social activity than the widowed respondents. A good marital relationship, not simply the status of being married, is thought to be an important predictor of well-being (Larson et al., 1986). The absence of marital harmony was reflected in the general well-being scores of two couples of the five in this study. Other variables
were considered when analyzing the results from these individuals' lower PWB scores, and after having interviewed them twice, some degree of discord became apparent.

Levels of perceived well-being in widowed people is thought to be lower than those of married people (Atchley, 1989). Similar results are evident in the present study using the PWB Scale (Reker and Wong, 1984). Widows had lower well-being scores. The lowest general well-being scores were from widows in their 80’s, who lived alone, and who reported moderate incomes. This may have been a result of the poorer health and diminished social contacts of the large proportion of widows (40%) in this study. Conversely, the greatest improvements in perceived general well-being scores were achieved by two widows: both 80 years of age; one lived alone, the other with her daughter and family; one in the $20,000 to $29,999 income range and the other at the poverty level. Because extraneous variables between tests were carefully considered and eliminated by thorough interviewing techniques, the author suggests that perhaps these differences in scores are a result not only of the homemaking support, but also a sense of control and hardiness. Sense of control suggests that individuals feel that they can make decisions and "take effective action to produce desirable outcomes and avoid undesirable ones" (Sarafino, 1990, p.113). This sense of control was displayed by a lady who lived alone and had no family or friends. She was a very responsible woman who although, her baseline well-being score was low, did manage to gain control over her life and lift herself out of her circumstances. I mention this because those were the words she used when I saw her six weeks later during the posttest interview. I believe she took steps to regain some of the control she felt she lost during her illness, she succeeded and this reflected in her well-being score.

The second lady with the greatest improvement was the stereotype of the strong-willed elderly woman we see in caricatures beating off would-be purse snatchers with her handbag. She displayed a special determination and perseverance often referred to as 'psychological hardiness' and assertiveness (Kobasa et al., 1982; Tobin, 1991). This hardiness, or bloody-mindedness as the British refer to it, is thought to diminish the impact of the very stressful events in life. According to Kozma et al. (1991), "Hardiness has been found
to account for 12% of the variance in happiness and the elderly” (p.94). Tobin (1991) has suggested that: “most critical to resisting the adverse effects of crisis is aggressiveness, that is, assertiveness, even combativeness in interactions with the external world facilitates adaptation to stress. Thus those who apparently can evade the developmental push towards increased passivity in advanced old age are better equipped to cope with stress” (p.19). A small number of respondents displayed this hardiness.

Income level and perceived psychological well-being are reported as being small, but nevertheless statistically significant (Larson, 1978). General conclusions around income suggests it is perceived financial satisfaction rather the actual income which is a more powerful predictor of well-being (Kozma et al., 1991; Lawton et al., 1984; Rodgers et al., 1988). That is to say, it is not the actual amount itself that predicts PWB but the satisfaction levels from the income that are important. If an individual feels she can live her life quite satisfactorily on $7,500 a year, the actual amount has no bearing on well-being; it is the satisfaction this amount offers.

The present study reveals a small but significant relationship between income and perceived well-being. While it is true that the highest perceived general well-being scores were achieved by elderly in the $20,000 to $29,999 income bracket, it is also true that the second highest score was achieved by a married woman whose combined income was considered to be below the poverty line. Results also revealed that the lowest perceived well-being scores were achieved by elderly widows also in the $20,000 to $29,999 income brackets. It may be that the size of the income is irrelevant if the extent of satisfaction with it is acceptable. One subject may be satisfied with living on $8,000 a year if she knows that she has more income than her neighbour, or conversely if she is aware that all neighbours live on $8,000 a year. Diener (1984) has referred to this phenomenon as the relative deprivation theory, and he suggests that other scholars interested in this area of study report that relative deprivation is significantly related to financial satisfaction, while income is not.

Education of subjects in the present study was not a predictor of well-being. The highest percentage of subjects (25%) reported a grade 12 education, followed by
approximately 22% reporting grade 10 levels. Those with the highest levels of perceived well-being reported education levels below grade 10.

Researchers such as Larson (1978), and Palmore et al. (1973) report that education has been a better predictor of life satisfaction in males. It seems appropriate that educated males would have higher scores in life satisfaction because, as supporters of families, they had access to greater occupational opportunities. One must also consider that this cohort's education level was high if grade 10 was attained and/or completed, as compared with the expectation today that high school is no longer considered sufficient or adequate enough to be competitive in today's work world.

Because of reported effects of health deterioration and chronic conditions on well-being, the expectation of the writer that health has a major effect on perceived and objective psychological and physical well-being is confirmed. Evidence of this is found in the quantitative and the qualitative data from both the objective measures of PWB and from the responses of respondents to questions at posttest. In particular, the recurring theme of self-health perceptions which became the primary theme to emerge from responses to the first qualitative question, seems to speak to the importance of health perceptions and perceived well-being. Sources of evidence are also provided by other researchers in this area of interest such as (Stock et al., 1983; Stoller, 1984; Reker and Wong, 1983; Cousins, 1979; Sarafino, 1990; Kozma et al., 1991).

It appears that as predictors of perceived general well-being respondents' self-health ratings are effective. Perceived physical health seems to exert a significant, direct influence on perceived general well-being, whereas objective (physicians or diagnostic) measures are negative and indirect (Kasl and Berkman, 1981). Subjective health (self-health ratings) appears to involve the subjects' own cognitive comparisons of the objective conditions, to those of their peers. Purely objective (physicians' diagnoses) measures do not involve such comparisons, and subjects, especially older people, have a tendency to believe what the doctor tells them or does not tell them (Stoller, 1984). It often seems that "what they don't know doesn't hurt them". And so it has been shown in individuals, that despite medical advice, if a subject feels good and believes his/her health to be good then
the perception of the individual becomes his/her reality. As well I noted when subjects were less aware of the severity of their health problems, their own subjective assessments reflected in a higher perceived well-being score. This finding is consistent with Kasl and Berkman's (1981) results.

The author had access to respondents' health status as a result of conversations with physicians before and/or after initial assessment of clients for homemaking services. Therefore, both objective (physicians') health measures and respondents' subjective (their own) measures were known by the researcher. Except for cases in which subjects were irremediably ill, as in the cases of terminal cancer patients, or those with sudden acute illness, subjects' own perceptions of health exerted a significant direct effect on perceived general well-being, whereas objective measures were often insignificant, and indirect. These findings concur with other studies and contribute to the empirical evidence of the inseparability of the mind/body (Cousins, 1979) and support the model of the biopsychosocial model of health, which implies that health and illness outcome is a consequence of the interplay of biological, psychological and social factors (Kleinman, 1980; Chopra, 1993).

Informants in this study expressed their approval and frequent satisfaction with the homemaker who visited them each week, or bi-weekly. Their behaviour during the posttest and the scores reflected the way they felt about this new social contact. Changes in scores of the PWB Scale and information shared by subjects during qualitative interviews adds to the research which reports strong correlations between social support, perceived well-being and perceived physical well-being (Blazer, 1982; Fillenbaum, 1984; Kart, 1990; Krause, 1990; Kane and Kane, 1981; Hogue and Gorton, 1981; Berkman and Kasl, 1981; Revicki and Mitchell, 1990; Conndidis, 1989). Subjects receiving the social support of homemaking actually scored higher at Test 2 on both the physical well-being and the psychological well-being categories. As Krause (1990) and Conndidis (1989) purport, social support serves as protection against adverse effects of stressful events through life. Further, social support is believed to facilitate adaptation to the crises and changes which occur during this period in life.
The most remarkable evidence for the significant effect of social support on perceived general well-being, but by no means the only one in this study, was the 84 year old widow, with no family or friends, who was extremely depressed and confined to her apartment because of arthritis at Test 1. She used a walker to ambulate. Within six weeks of homemaking this lady was bowling three times a week with a group of ladies she met as a result of an introduction by her homemaker. Where she previously had no social contacts, she now has more lady friends than she can handle. In fact, when the writer arrived at the subject’s apartment for the second interview, she was greeted at the door, not by the respondent, but by her friends, of which there were six. The subject was having an ‘after-bowling tea party’. Her change in PWB scores, as well as her comments to me about her homemaker and the wonderful deed she had performed by introducing her to all these friends reflected a significant increase in this subject’s well-being and perceived health status, as a result. Examples from other respondents’ interviews were also evidence for the significance of social support. Phrases like: "it’s so nice to know that someone will come and see me next week", "I enjoy her visits so much", "when she’s here I feel better", "she gives me something to look forward to".

The unanticipated results in this study reflected the significance of instrumental support. The author has chosen to use the word, ‘instrumental’ by way of comparison to the emotional or social support given to respondents by homemakers. Instrumental support, for purposes of this research, is the actual tasks which were performed by paid homemakers, in respondents’ homes as dictated by assessors from Continuing Care. This support included household tasks such as vacuuming, mopping, and dusting, bathroom and kitchen cleaning, assisting with bathing and hairwashing, and small meal preparation or assistance. The importance of such instrumental tasks to female respondents particularly, became very evident when themes of gender identity, social expectation, roles, and self-esteem began to emerge during the posttest response to question 2: What is your opinion of the homemaking service? of the qualitative interview. Not only were the housecleaning tasks important to subjects, but also the quality of such work took on an increased significance as interviews progressed.
Women of this cohort appeared to have gained and/or maintained their identity through the role of homemaker and housewife. This identity has been maintained into old age, even after spouses died. Mac Rae (1989) saw this role as "a very meaningful and focal component of their self identities" (p.256). The homemaker role is a source of continuity in self-identity for the women in this study. These results concur with results from other studies in the area of female role and self-identity that report the importance of continuity in identity (Mac Rae, 1989; Matthews, 1979; Lopata, 1966).

Subjects were not encouraged to disclose information about the values of housekeeping, but rather were asked to expand upon the information as it was related to the researcher during posttest interviewing. Perhaps the surprise element should have been unwarranted because of the importance of maintaining a clean house myself. I had never really analyzed my feelings about my need to maintain my home at very high standards, however, after hearing the stories of the twenty ladies, I came to see that they echoed my sentiments exactly, and the stories about their childhood and their mothers sounded much like stories of my own training and conditioning to be a good housewife. Issues of control, pride and independence served to exemplify the importance of the instrumental help they received from homemaking agencies.

If a woman’s self-esteem is elevated because her self-identity is still in tact as a result of being able to “keep house”, even if it is with help from a homemaker, it follows that her perceived well-being will be positively affected, and possibly her perceptions of her health as a final outcome. The results of the data in this study provide evidence for the aforementioned effects and outcomes. If the provision of homemaking services impact upon the perceived well-being, and subjective health status’ of clients in such a way, then Continuing Care has met its mandate practically as well as theoretically.

Although these results are not generalizable, they do provide the impetus to study this area further. There are several issues and concerns around the research method which provide thought for future researchers.
Recommendations for Improvement in Research Methods of the Elderly

Because of time constraints and lack of economic resources, this research was limited. Other researchers need to consider the importance and impact of the random sampling method. The subjects of this study had to be recruited as they came into the Continuing Care Program because of time constraints, but if this writer were to attempt to replicate this study a random sampling technique would be imperative. Also, the lack of control groups due to time and resource feasibility meant that it was impossible to make a causal relationship between homemaking and well-being. A control group could possibly have been recruited by using clients who refused homemaking services, even though this happens infrequently and it could prove to be extremely time-consuming to wait for such subjects. The difficulty of obtaining a control group with the exact levels of chronic conditions is also an almost insurmountable undertaking, however future researchers might consider advertising for elderly subjects with comparable chronic conditions and needs as a means of control. There are older adults who require homemaking assistance but are too proud to admit to the need or to ask for help. As well, there are also elderly people in need who are unaware of the resources available. One might advertise for subjects in the seniors community centres and through volunteer groups.

Another method of collection which eliminates the need for longitudinal study is the 'cohort analysis'. This method involves collecting the same information at different times, with different respondents in the same age cohort being studied each time. The idea is that while respondents are different, they are usually representative of the same age cohort. Changes with age as well as differences between age cohorts may be inferred (Schaie et al., 1988).

In a similar study to this one, I would recommend improving the longitudinal methodology. There are very few studies that examine the same group over time. The reason for this dearth of longitudinal data is because this type of study is expensive to conduct and time-consuming to complete. A more effective method of detecting changes over time might include taking measures over three or four different times instead of two, as was the case in the present study. I am suggesting that in this study, subjects' increases
in perceived well-being scores may have been influenced by changes in the season.

Pretesting for this study was conducted shortly after a long, cold, and difficult winter for older adults. Most subjects had been confined to their homes for many weeks when they were first interviewed. It is conceivable that they suffered a form of seasonal affective disorder (SADS) which is characterized by depression beginning each year in the fall and remitting or switching to mania in the spring when days start to lengthen (Rosenhan and Seligman, 1989). It affects women more than men (4 to 1), and the depression seems to be governed by the amount of sunlight one receives. It is no accident that older retired people “go South” in the winter months. Travel to sunnier climates causes a remission of depression within days according to Rosenhan and Seligman (1989).

The category of SADS is a relatively new one in the DSM 111, and there has been little research in the area of SADS and the elderly, although there have been some recent studies on seniors and winter in Canada. For example, in the February 1989 report of the National Advisory Council of Aging, monographs by researchers such as Michael Persinger, Professor of Psychology and Neuroscience; Dr. Charlotte Matthews, Gerontologist; Dr. Cyril Gryfe, Consultant in Geriatric Medicine; Josee Verdon, Fellow in Geriatric Medicine; and Harold A. Hanen, Faculty of Environmental Design, University of Calgary, report mood fluctuations, loss of independence, increased health problems and infections, and decreased mobility and activity in Canadian seniors as a result of winter life. This writer recommends further repeated measures studies on the elderly be conducted with seasonal changes in mind, and that measurements be recorded at each season of the year to control for the effects of seasonal affective disorder.

Although recent interest in the elderly has produced a large amount of literature, the research itself can be inadequate in terms of basic research standards. Several problems are worth considering in the study of elderly people.

The first problem is the relatively few trained gerontological social workers and other scholars available to conduct gerontological research, and train others to work with the aged. Although it appears that programs and courses in gerontology are on the increase, there still are few gerontologists and social workers with specialized training at
this time in Canada to satisfy the need and demand.

Secondly, future researchers of the aged might consider the importance of research instruments for the elderly. There have been relatively few research instruments designed specifically for the aged. Many of those that have been designed for older adults have questionable reliability and validity (Kane and Kane, 1981). It is absolutely essential today to employ instruments that are appropriate for the problems and people studied. Elderly people fatigue easily, do not perform at their maximum capacity on timed tests, experience visual changes that create difficulty in reading small print, and have fewer education years than younger adults. All these add up to testing difficulty and unreliability if the test is not developed with the older adult in mind.

A third problem involves the knowledge of the aged that is required to conduct adequate interviews. This researcher found interviewing subjects to be extremely time-consuming because very old people do not comprehend as readily; they take time to form their thoughts; they are unsure of themselves, and they like to talk about themselves and frequently digress during interviewing. The often feeble state of an aged person may alter the interview situation so that the interviewer may try to hurry through the statements or questions, even though an interview with an old person should be slow-paced. Previous knowledge and training helped this investigator considerably, but it can be difficult for researchers who lack knowledge of the aged. In trying to elicit information from very old adults, researchers need to remember to be patient, enunciate clearly, and eliminate the use of jargon.

*Recommendations for Future Social Work Research*

My first recommendation is that more social work research be accomplished in the field of gerontology. In the literature, there are sparse studies in this area, partly because studies of the elderly are relatively new, and also because there are also few trained gerontological researchers. Study of the elderly is still in its infancy, but growing quickly and now is our chance to make valuable contributions to this new and exciting field.
My second recommendation is directed at educational institutions. As students we require more knowledge of our elderly population. Very few universities in Canada have electives in gerontology, and even fewer have full-time studies in the field. Simon Fraser University in British Columbia offers a Post Baccalaureate Diploma in Gerontology and more recently has instituted a Masters Program to commence in the Fall of 1994. This will only be the second program in Canada to offer such degrees. University of Victoria on Vancouver Island offers a Masters and PhD program in the faculty of Psychology which examines the life span development in aging. Because of the changes taking place in our health care system and the proposals to put health care into the community, it is imperative that social workers be afforded more extensive training in the area of research, counselling the elderly, and understanding the problems of this growing population.

In working with the elderly, it is not uncommon for concrete services to be offered in combination with counselling services, as Case Managers of Continuing Care can attest. Counselling service provided through our Home Care Program is more likely to be short-term-oriented rather than ongoing. It is often task-centered rather than psychotherapeutically focused. Issues of concern revolve around the chronic conditions of clients, death and dying, adjustment to functional limitations, grieving the losses of healthier days and friends and family, understanding disease processes, aging, love, marriage difficulties, and ethnicity.

In my experience as a gerontological social worker, I have found when dealing with the elderly one should be prepared to cope with resistance. Counselling in issues of loss of health, family supports and finances are extremely difficult, and simple resolutions are not likely to be forthcoming. Resistance may surface in the form of anger, frustration, disappointment, discouragement, manipulation, and ambivalence. Undue anger is frequently directed at the social worker or case manager. There is much to learn about the elderly client if we are to work effectively with them. It is imperative to be sensitive to their issues.

It has also been my experience that there is a scarcity of evaluation in many government programs. As social work researchers, we can offer our services and
contributions by researching these programs to test their effectiveness and efficiency. I would encourage my colleagues to become excited about this frustrating but thoroughly satisfying process.

More work needs to be done in the area of homemaking and client well-being. This study has only minimally scratched the surface. Studies in various levels of care, gender, age groups, ethnic groups, types of illness and disability, income levels, and educational levels need to be considered; all these areas need to examined separately and together in longitudinal studies. Qualitative studies of homemakers could yield rich data.

The issue of dependency is an area which needs exploration. Are we helping clients to maintain their independence, or are we creating dependency by supplying this kind of service? Case Managers in Richmond Continuing Care are asking this question.

_Interviewer Impressions_

As interviewer, I frequently felt anxious about my behaviour. It is imperative to try to control for experimenter effects. I did this by attempting to keep my behaviour constant, and I designed the questioning format in a way that would allow for consistency in administration. I found the rigidity of trying to keep control and constancy to be somewhat artificial and there were times when I would like to have been carried away by my subjects' stories and become more involved, but I realized I had a task to perform and conducted myself accordingly. In a way, this action was probably to my advantage because it kept me thinking about the experimenter's effects problems throughout the interviews. If I were to conduct this study again, I would hire interviewers to do the work I have done by myself because of the enormous amount of time it takes to do a repeated measures quantitative and qualitative study with 28 subjects. I found the process of interviewing elderly to be physically, mentally, and emotionally draining.

Because of the time involved, and the difficulties in listening to and recording conversations which often were difficult to comprehend because of digressions, speech and hearing problems of some of the subjects, and the difficulty in distancing oneself from
the often painful reports of some subjects and trying not to "do social work", the process was exhausting. I would suggest it might be wise to use interviewers in spite of problems of control simply to see if the present results can be replicated.

**Recommendations for Homemaking Services**

My impression is that many of the subjects' negative opinions in this study are the result of not fully understanding the reason behind the service. As assessors we try to inform clients that the homemaking service is designed to help individuals maintain their independence in the home and community by assisting with tasks that the recipient or his/her family cannot perform. Many subjects believed the service to be a "maid service" because of hearsay from other clients who have the service, or from friends, and complained to the writer when certain housecleaning tasks were not done to their specifications. This problem might be dealt with before the complaint arises by exemplifying the purpose of the homemaking service to clients; both homemaking agencies and Continuing Care case managers could emphasize the difference between what we are providing and a professional cleaning service, and the purpose of providing the service.

Another complaint from subjects was the variations in services provided by some homemakers. Although there is a specified home support plan which is offered to clients, respondents claim that homemakers frequently stray from the home support plan, perhaps with good intentions, but because clients often communicate with each other the word eventually gets out that "Mr. S__ has his shirts ironed last week so why can't I?" Or," Mrs. C's homemaker takes her shopping, why can't my homemaker do the same?" This type of inconsistency in service delivery might be rectified if all homemakers either performed the same tasks or perhaps if the client were given more flexibility in the types of services or tasks we offered.

Too often we dictate the services and the client is the passive recipient. An important pilot program is underway in Manitoba, where the client is not the passive recipient of services. Instead he or she is given total control of the services they desire by
issuing them a monthly cheque to buy their own services. This study is being conducted by Eckhard Goerz, MSW, Manager of Continuing Care/Home Care Program in Manitoba. Mr. Goerz has initiated a two-year pilot project during which 30 clients of the Home Care Program receive funds in lieu of service. The funds are provided directly to the individuals who then assume full responsibility for recruiting, employing and training their care providers. This project is currently past the mid point of its two-year term and reports to date suggest a high level of client acceptance with minimal administrative difficulties. Moreover, the client no longer is a passive recipient and has an active voice and participation in his/her needs. The model could be useful to future planners of homecare for our increasing population of elderly.

Another complaint from the subjects in this researcher's study was the difficulty in adjusting to new homemakers who are sent to client's homes because of scheduling difficulties. Often when a client becomes accustomed to his/her homemaker a trust or confidence grows. A change in homemakers requires that the client gather his or her emotional resources and physical energy to deal with someone "new". For clients who are particularly weak, the task of showing a new homemaker where things are in the home can be exhausting and frustrating. The changing of homemakers without consulting the client is seen as another relinquishment of his/her independence, and the recipient of the service is frequently put into the position of "having to accept whatever is given from whomever gives it" (Barer, 1992, p.140).

Initially subjects experienced some discomfort when the homemakers were introduced into their homes. Not only was the service tangible evidence of their inability to function independently, but also it was seen as an intrusion - an invasion of privacy. For the homemaker, the task of working in a new home can be just as traumatic, and it would appear that adjustments have to be made for both homemaker and client in order to produce a workable relationship. According to Barer (1992), "primary relationships frequently develop out of the secondary provider/client relationship. Rarely does the provider of homecare services remain an anonymous entity" (p.138). And this was the response in 92% of subjects who reported a kind of bond forming between themselves and
their homemaker. This response hearkens back to my point about consistency in homemaker assignment. At a time when elderly people feel overwhelmed by changes in their lives, it is important to try and provide as much consistent care and attention as possible in order for them to adjust to the multitude of inconsistencies that invade their lives in their later years.

**Conclusion**

The obvious advantages of homecare is that most older people prefer it. Care at home offers better morale and security as long as proper services are given to provide comfort, support, and direct treatment of physical and emotional ills. The older person and the people in his/her life have a different perception of illness and treatment in the process of home care. Instead of being placed in a hospital or facility, people remain where their care can be observed and where they can participate in that care. They are not passive recipients of care. It becomes evident to family members and older people themselves that mental or physical illness can be lived with as long as the stress on the caregivers does not become too onerous. Life does not have to stop or become totally disrupted, and rehabilitation and recovery can occur even in a proportion of the very old and the very sick.

Through this study I have learned that home is significant to many older people. It is a part of their identity. Home is where things are usually familiar and relatively unchanging, and a place where they can maintain a sense of autonomy and control at a time when so many changes are taking place in their lives. Some insist upon remaining at home regardless of the cost to their emotional and physical health and personal security. Such tenaciousness may be attributable to the need for autonomy and independence; a fear of loss of contact with familiar and loved people, places and things; a fear of dying, because of the reputation of hospitals and nursing homes as place "where old people go to die"; and a trepidation about change and the unknown, which frightens all of us no matter how old we are. In Canada, the idea of home is highly valued and cherished and communal or institutional living is often viewed as a loss of personal liberty and dignity.
The notion of home can refer to many things, from the four walls surrounding a person, to the neighbourhood in which one's residence is located, or to the possessions that make us feel at home. The meaning of the word home may include other individuals living with a person, as well as neighbours, pets, and plants. Home is a place where many women gain and maintain a sense of identity because of the pride they take in making a comfortable place for their families to grow up in. Home is often one's castle, as the saying goes. It can be either a place where one has lived a good part of one's life or a new place, as when older people move into a retirement community. The concept of home is unique to each individual.

Home can also be a euphemism. In our eagerness to recognize the importance of the feeling of home, we should not overlook those elderly people who dislike their living conditions, who have never 'felt at home' where they are, and who are eager to move somewhere else - even to an institution.

The identification of the effect of homemaking services on client well-being was the major objective of this study. The study has revealed a change in the standard measure of perceived well-being using Reker and Wong's 1984 Revised PWB Scale, after the introduction of six homemaking visits. Quantitative methods were used primarily and data was triangulated using a qualitative questionnaire with a view to enhancing and illuminating the results. Because homemaking has been viewed by some as a panacea for health care problems of the elderly in terms of a cost effective alternative to institutionalized care, it was important to this researcher to try to answer the question: Does it actually do the client any good? Results from this study indicate that homemaking does help some community-dwelling elderly people maintain a kind of independence in the community. For many subjects, perceptions of health status improved and general well-being scores changed significantly. However, many questions remain unanswered. Does the service reduce the incidence of institutionalization and does it increases the amount of time a client stays at home before being placed in a facility? There is much research to be conducted in this area.
BIBLIOGRAPHY


APPENDICES
Appendix A

Letter Inviting Subject Participation
Dear Continuing Care Client:

As part of her master's thesis, Eileen Dougall Reilly, RSW, will be conducting a study of elderly community-dwelling people who will be receiving homemaking services through the Continuing Care Division of the Richmond Health Department.

This study is an investigation of the perceived "well-being" of elderly people both before and after homemaking services have been provided. Your co-operation in this project would be of significant value in the improvement of services to senior citizens.

If you would like to participate in this research, please inform your Case Manager at the time of your assessment interview and she will give your telephone number and name to Eileen Dougall Reilly, who will contact you by telephone within 24 hours to arrange a meeting with you in your home, at your convenience.

Your participation is voluntary, protection of your identity is ensured, and any information you choose to share will be completely confidential and will in no way affect your application for homemaking services.

We anticipate that the results of this study will serve to improve the quality of service(s) not only to yourself, but also to future clients of the Richmond Continuing Care Division.

Sharon Manson Singer, PhD.
Principal Investigator

Eileen Dougall Reilly, RSW
Co-Investigator
Appendix B

Letter Explaining Study
Eileen Dougall Reilly is conducting a study of community-dwelling seniors who have recently been assessed by the Continuing Care Division of Richmond Health Department to qualify for homemaking services. This study is an investigation of the perceived "well-being" of elderly people both before and after homemaking services have been provided.

Your voluntary participation in this study will enable Eileen Dougall Reilly to complete her master's thesis and provide valuable data which will serve to improve the quality of service(s) not only to yourself, but also to others who utilize Continuing Care.

You have the right to refuse to participate. You may withdraw at any time without affecting your application for homemaking services. You are under no obligation to become involved in this study, however we shall view your participation in the first interview as constituting your consent. We assure complete confidentiality of any information you choose to share.

This study will consist of two private face-to-face confidential interviews. During the first interview you will be asked to respond to 16 short statements which may or may not describe the way you feel at that time. The interview will take about 30 minutes of your time. Six to eight weeks later Ms. Reilly will contact you by telephone to arrange for the second interview. All information will be codified to ensure your privacy. All records will be stored in a locked file cabinet and any reference to names and phone numbers will be purged from the data and destroyed by shredder as soon as the information has been processed.

It is our sincere hope that your contribution to behavioural science research will be a rewarding experience.

If you have any questions regarding this study please phone:

Eileen Dougall Reilly, RSW 272-4169
Dr. Sharon Manson Singer 822-3251
Appendix C

Letter Requesting Agency Permission
Ms. Bev Latrace,
Director, Continuing Care Division,
Health Department,
300 - 8120 Granville Avenue,
Richmond, B.C., V6Y 1P3

Dear Ms. Latrace:

Please accept this letter as confirmation of our verbal agreement that Richmond Continuing Care Division will permit me to conduct research for my masters thesis contingent upon approval from University of British Columbia Ethics Committee early in the new year (1993).

I look forward to a successful and mutually rewarding experience in Continuing Care Division.

Thank you for your kind consideration of my request.

Yours truly,

Eileen Dougall Reilly, RSW
Appendix D

Pretest Format for Qualitative Interview
What do you like most about the homemaking service?

What do you like least about the homemaking service?

What would make the service better?

How did the homemaker make you feel?
Appendix E

Perceived Well-Being Scale
PERCEIVED WELL-BEING SCALE - REVISED

Gary T. Reker

This questionnaire contains a number of statements related to your mental and physical well-being. Read each statement carefully, then indicate the extent to which you agree or disagree by circling one of the alternatives provided. For example, if you STRONGLY AGREE, circle SA following the statement. If you MODERATELY DISAGREE, circle MD. If you are UNDECIDED, circle U. However, try to use the UNDECIDED category sparingly.

<table>
<thead>
<tr>
<th>SA</th>
<th>A</th>
<th>MA</th>
<th>U</th>
<th>MD</th>
<th>D</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>STRONGLY AGREE</td>
<td>MODERATELY UNDECIDED</td>
<td>MODERATELY DISAGREE</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I have many physical complaints. SA A MA U MD D SD
2. No one really cares whether I am dead or alive. SA A MA U MD D SD
3. I think that I have a heart condition. SA A MA U MD D SD
4. I have plenty of physical energy. SA A MA U MD D SD
5. I am often bored. SA A MA U MD D SD
6. I have aches and pains. SA A MA U MD D SD
7. It is exciting to be alive. SA A MA U MD D SD
8. Sometimes I wish that I never wake up. SA A MA U MD D SD
9. I am in good shape physically. SA A MA U MD D SD
10. I feel that life is worth living. SA A MA U MD D SD
11. I think my health is deteriorating. SA A MA U MD D SD
12. I don't seem to care about what happens to me. SA A MA U MD D SD
13. I don't get tired very easily. SA A MA U MD D SD
14. I can stand a fair amount of physical strain. SA A MA U MD D SD
15. I have peace of mind. SA A MA U MD D SD
16. I am afraid of many things. SA A MA U MD D SD
Appendix F

Scoring Instructions for Perceived Well-being Scale
1. **Psychological Well-Being** (Items 2, 5, 7, 8, 10, 12, 15, and 16)
   - For Items 2, 5, 8, 12, and 16
     \[ SA = 1 \ldots SD = 7 \]
   - For Items 7, 10, and 15
     \[ SA = 7 \ldots SD = 1 \]

   Lowest score = 8; highest score = 56

2. **Physical Well-Being** (Items 1, 3, 4, 6, 9, 11, 13, and 14)
   - For Items 1, 3, 6, and 11
     \[ SA = 1 \ldots SD = 7 \]
   - For Items 4, 9, 13, and 14
     \[ SA = 7 \ldots SD = 1 \]

   Lowest score = 8; highest score = 56

3. **General Well-Being**: Sum of psychological and physical well-being.

   Lowest score = 16; highest score = 112
Appendix G

Letter of Permission to Use Perceived Well-Being Scale
January 5, 1993.

Ms. Eileen D. Reilly  
66-6600 Lucas Road  
Richmond, BC  
V7C 4T1

Dear Eileen:

The enclosed material may not reach you in time. In any event, you have my permission to use the Perceived Well-Being Scale-Revised for your Masters thesis.

The scoring key is enclosed. Three measures can be obtained: psychological well-being, physical well-being, and general well-being. The statistical analysis will depend on your research design. I assume that a control group will be used in a pre-post experimental design. Treat the pre-scores on each measure as a covariate and compare adjusted post scores for subjects receiving homemaking services with those not receiving such services.

All the best with your research.

Sincerely,

Gary T. Reker, Ph.D.  
Professor
Appendix H

Agency Consent Letter
November 27, 1992

Dr. Sharon Manson Singer  
School of Social Work  
University of British Columbia  
2080 West Mall  
VANCOUVER, B.C.  
V6T 1Z2

Dear Dr. Singer,

This letter is to acknowledge that Eileen Dougall Reilly has been approved to conduct her research for her Masters Thesis in the Continuing Care Division of the Richmond Health Department in the new year (1993), contingent upon approval from the University of British Columbia Ethical Review Committee.

Yours truly,

Beverley Latrace,  
Director, Continuing Care Division,  
Richmond Health Department.

BL/aa
Appendix I

Ethics Approval Letter (UBC)
Notice of Ethical Review

Manson, S.

Social Work

Simon Fraser University

Simon Fraser University, St. Paul's Hospital, BC Children's Hospital Fdn

Class Project

The Committee has reviewed the protocol for your proposed study, and has issued a Certificate of Approval on the condition that evidence that the following requirements have been satisfied will be supplied to the Office of Research Services before commencement of the research:

In addition to Dr. Manson Singer's recommended changes in Appendix 1, the following additional points must be addressed:

1) McLaughlin: Put the consent form on UBC letterhead.
2) Anderson: Put all letters and forms on UBC letterhead.
3) Mackinnon: Explain how the 27 participants in the second survey will be identified.

If you have any questions regarding these requirements, please call:

Dr. Barbara McGillivray, Chair, 875-2157
Dr. Allan Hannam, Associate Chair, 822-3416
Ms. Shirley Thompson, Manager Ethical Reviews (ORS), 822-8584

PLEASE SEND ALL CORRESPONDENCE TO:
THE OFFICE OF RESEARCH SERVICES, 323 WOODWARD-IRC
UBC CAMPUS ZONE 3
Appendix J

Richmond and Lower Mainland Continuing Care Stats
STATS - EFFECTIVE FEBRUARY 28, 1993

**CCD Homemaker Services**

<table>
<thead>
<tr>
<th></th>
<th>Richmond</th>
<th>L.M.(Ex. Rmd)</th>
<th>Province (All Units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Clients</td>
<td>1,320</td>
<td>16,492</td>
<td>44,019</td>
</tr>
<tr>
<td>No. Hrs. Srv./Mos.</td>
<td>15,969</td>
<td>222,205</td>
<td>580,603</td>
</tr>
<tr>
<td>Average Hrs. Per Client/Mos.</td>
<td>12.09</td>
<td>13.47</td>
<td>13.19</td>
</tr>
</tbody>
</table>

(L.M.) Lower Mainland = Boundary
North Shore
Vancouver
Burnaby
Simon Fraser
Appendix K

Telephone Follow-Up Conversation
Example of telephone conversation used at initial recruitment after LTC assessors asked clients if they would be interested in participating in the study:

Hello Mr/Mrs_____

This is Eileen Dougall Reilly calling. MrsAssessor has just called me to tell me you might be interested in participating in my research project through the University of British Columbia and Continuing Care. As ____ (Assessor) has probably mentioned to you, although I work as an assessor for Continuing Care, myself, I am also a graduate student in the faculty of Social Work and I am studying community-dwelling senior citizens like yourself who have been referred for homemaking services. Do you think you might still be interested in participating in my study?

(If answer is yes) - Thank you very much. I would like to come to see you at your home at your convenience to have you respond to some statements about how you're feeling. What time and day do you think would be convenient for you? Thank you for agreeing to be part of my study. I'm sure you will find it interesting.

(If answer is no) - Well, thankyou, I understand. I certainly don't want you to feel obligated to participate. Your acceptance or refusal will certainly not affect the provision of your homemaking service. Thank you for considering it, however, Good bye.
Appendix L

Qualitative Questionnaire
Qualitative Questionnaire
(Restructured format)

1. What, if any significant changes have taken place in your life over the past 6 (8 or 10) weeks?

2. What is your opinion of the homemaking service?

3. How do you view your homemaker? (Or what is your opinion of the homemaker, if the wording is not understood properly by subject)

4. What would you like to see happen that might improve the homemaking service for you and other Continuing Care clients?
Appendix M

Thank You Letter to Respondents
Dear

I am writing you to thank you for your valued participation in my research. As you recall, I asked you a number of questions about the way you were feeling, before we started homemaking for you and then several weeks after. I was interested in measuring your perceived psychological and physical well-being before and after services to see if there were any changes in your scores after six homemaking visits.

The results of the study show that most of your well-being scores did, in fact, improve after you received homemaking services from Continuing Care. It also appears that homemaking services and the homemaker may have been instrumental in enhancing your sense of well-being. At this time I am unable to infer causation, but hopefully this study will provide the impetus for further evaluation and studies in this important area.

As well, you shared with me some of your concerns and praises about the service, and this information was valuable. It is our plan at the Health Department to take your comments seriously so that we may improve our service to you.

I would like to thank you for sharing your valuable time and thoughts with me, and allowing me into your lives for a short time. It was a great privilege to know you. I hope your contribution to social sciences research and my masters thesis was as enjoyable as it was for me. I hope to see you all this summer as I will be working again for the Continuing Care Department as an assessor.

Sincerely,

Eileen Dougall Reilly, BA, BSW, RSW.