ACTIVITIES WITH FAMILY MEMBERS THAT ARE VALUED BY RESIDENTS OF A LONG TERM CARE FACILITY

By

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Abstract

The purpose of this study was to describe the activities with family members that are valued by residents of a Long Term Care Facility (LTC Facility) and to identify relationships between the demographic characteristics of the residents and their families and the activities that residents value. Data were collected from fifty residents of a LTC Facility using the modified Questionnaire for Resident/Patient (Dobrof, 1976).

The results of the study suggest that residents value a number of activities with members of their modified extended families. Activities that are most valued are visits, phone calls and personal assistance with transportation to outside appointments and clinics; and shopping with or for residents. Those subjects with a surviving child were found to have a significant number of visits, phone calls, and exchanges of cards with daughters as well as visits to their homes. It was also found that a significant number of subjects named daughters as their key relative. Those subjects without a surviving child named significant others, siblings, nieces and nephews as their key relatives. It was found that as the subjects' Level of Care increased so did the assistance with personal care activities that they received from significant others. Additional findings suggest that many subjects do not want to exchange gifts with family members; that contacts between subjects and their relatives have stayed the same or increased since placement; and that less than half

of the residents have been asked by their family members about the types of activities they would like family members to have with them.

The study results give direction for nurses to facilitate and encourage discussion between the elderly and their families about the activities they value together; to use this information in counselling family members and significant others in the ways that they may be supportive to their elderly relatives' as their conditions change; in planning activities and care for residents of LTC Facilities; and to be alert to ways to provide support and assistance to daughters.

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CHAPTER ONE

Introduction

Background to the Problem

Population studies show that the number of elderly people in Canada, as in other countries, is increasing at a steady rate. Between 1891 and 1921, about 5% of Canadians were aged 65 or over. By 1981, this group represented 9.7% of the population (Statistics Canada, 1982).

The phenomenon of having such a large elderly population creates a number of problems for the elderly, their families, and the nurses caring for them. Many of the elderly, now in their 70's, 80's or 90's, are without role models on which they can pattern their later years. Few of their parents or their parents' siblings lived into old age. This lack of role models, together with diminishing physical and sensory capabilities can cause the elderly uncertainty about their future and their ability to handle it.

The families of the elderly may also lack role models to guide them in their long term support and care of elderly relatives. Although families assisted with the care of their elderly relatives in the past, it was generally for a much shorter period of time. Life expectancy was shorter and the elderly did not usually live long enough to develop the chronic medical conditions experienced today.

As they adapt to their new roles as helpers and caregivers to elderly relatives, family members use a variety of familiar social exchanges. These social exchanges vary from providing assistance with household chores, visiting, shopping, and escorting to appointments, to the provision of direct physical care and room and board for the elderly within a relative's home. When the strategies for supporting elderly relatives include institutionalization in a Long Term Care Facility (LTC Facility), the emphasis of social exchanges shifts from providing physical care and shelter, to providing emotional and social support to elderly relatives in their new environment.

Nurses are encountering the elderly and their families in increasing numbers in the community, in acute care hospitals, and in other health related settings. This presents new challenges to nurses as they strive to increase their knowledge and skills in caring for the elderly and providing support to them and their families. Nurses are frequently consulted by family members about the needs of their elderly relatives and are asked for suggestions about the ways that family members can provide support to them. In order to increase their skills in caring for and providing support and direction to the elderly and their relatives, nurses must have an understanding of the changing needs of the elderly and their families, and the wishes of the elderly about their care. To gain more knowledge about the wishes of the elderly, this study focuses on the residents of a LTC

Facility and solicits their views regarding the types of activities that they value with their families.

Conceptualization

Exchange theory provides a theoretical basis for viewing the activities that occur between family members. The basic principle underlying exchange theory is that one individual supplies rewarding services to another, creating an obligation in return. To discharge this obligation, the second individual must furnish benefits to the first individual (Blau, 1964). Exchanges typically involve economic considerations.

Social exchange theory is a variation of exchange theory. It is more socially focused and can be used to explain family relationships. Social exchange refers to "an exchange of activity, tangible or intangible, and more or less rewarding or costly, between at least two persons" (Homans, 1961, p.13). The benefits exchanged in these activities are valued as symbols of the mutual support and friendliness they express and are not necessarily of an economic nature (Blau, 1964). Although exchanges may be unequal, as with the very young or elderly, individuals stay in the family group because the relationships are rewarding and are perceived to be more satisfactory than other alternatives (Sussman, 1976). Social exchanges can also occur amongst relatives living in different geographic locations,

because shared sentiments among family members are not totally dependent on spatial proximity (Moss, Moss & Moles, 1985).

Within the context of social exchange, norms tend to develop that require individuals to set aside some of their personal interests for the sake of the collectivity (Blau, 1964). For example, family members may assume a considerable burden in caring for an elderly family member with little apparent return for their effort as part of the norm of accepting responsibility for and providing help to family members.

Sometimes individuals are in exchanges which result in unequal rewards. They are said to be in power relationships. Declines in their financial, physical, and mental resources are likely to put the elderly in a position of disadvantage or powerlessness in social exchange relationships because they are unable to contribute equally in these exchanges. When this happens, all that remains of their power resources is the humble capacity to comply to the wishes of others (Dowd, 1975). Giving the elderly the opportunity to choose the types of social exchanges in which they want to participate can help to avoid putting them in this position of powerlessness.

Exchange theory provides a basis for viewing the activities that occur between family members and their elderly relatives in LTC Facilities. As a result of the increased number of elderly in the population, many families are having this new experience of having their elderly relatives institutionalized. Although approximately 5%

of the elderly require care in institutions (Shanas, 1979), studies show that the elderly and their family members usually view long term institutional care negatively (Shanas, 1979; Smith & Bengtson, 1979). Institutional care seems to represent a public acknowledgement that the elderly individual is in a marginal state, requiring support and assistance (Rosenmayr, 1977). As well, the public generally believes that nursing homes provide substandard care, and residents tend to be depressed, unhappy, and intellectually ineffective, possessing a negative self-image, and having a low interest in their surroundings (Smith & Bengston, 1979).

As a result of these negative views, the decision to place a relative in a LTC Facility is a difficult one for families and their elderly relatives to make. In spite of the fact that many family members are relieved to be free of the burden and exhaustion of caring for their elderly relatives, this decision is likely to make them feel they have failed as caregivers (Cath, 1972; Sancier, 1984; Savitsky & Sharkey, 1972). To many of the older people, institutionalization symbolizes the ultimate loss of independence (Silverstone & Hyman, 1976).

Although family members may have mixed feelings about the institutionalization of their elderly relatives, they continue to have an important role in their care after placement. Because the institution takes over the technical tasks of care, the focus of the family's role becomes one of offering psychological and social

support to their relatives through such social exchanges as visits, special food treats, outings, and phone calls (Dobrof & Litwak, 1977). Social exchanges of this type give family members and their elderly relatives opportunities to interact and provide mutual support to each other.

Although there is a lack of literature about this subject, it is this researcher's experience that many families assume a position of power in their social exchanges with their elderly relatives. In spite of the fact that many of the institutionalized elderly are still capable of decision making, it is often the family that decides the type of supportive activities that they will have together. This unilateral decision making by the family may be explained by: the absence of role models and a lack of knowledge about and sensitivity to the needs of the elderly; societal expectations to care for one's relatives; a family's feelings of guilt about having their relative in an institution; and the demands placed on the time of family members by their many responsibilities. Although the elderly are capable of articulating their desires, their position of powerlessness and their lack of role models may contribute to their hesitation to express their wishes about the social exchanges they share with family members. Nevertheless, the institutionalized elderly value their activities and social interactions with family members.

The activities that family members usually do with, or for, their elderly relatives in institutions have been identified (Dobrof, 1976).

Fourteen activities, or social exchanges, have been documented as ways that families provide support to their relatives. However, little data is available about the residents views about these activities. A review of literature reveals that little research has been done to obtain the views of elderly residents of a LTC Facility regarding which of these supportive activities, or social exchanges, they value with their family members.

Problem Statement

Fourteen activities through which family members maintain contact and share in the care of their institutionalized relatives have been identified (Dobrof, 1976). However, there is a lack of research data about which activities are important to residents. Therefore, this study asked the research question: Which activities with family members are most valued by the resident of a LTC Facility?

Significance to Nursing

Knowledge of the types of activities that are most meaningful and supportive to residents would be useful in counselling and providing support to residents and their family members. This knowledge could be used in preparing the elderly and their families for placement in a LTC Facility, during the relocation period and after adjustment to the LTC Facility. This knowledge would also be useful to nurses in

developing activity and care programs that would facilitate these valued interactions.

Purpose of the Study

The purpose of this study was to explore and describe the activities with family members that were valued by residents of a LTC Facility. Specific questions to be answered were:

1) Which activities with family members do residents value?

2) Is there a relationship between demographic characteristics and valued activities?

Definition of Terms

1) Activities-the actions and sets of behaviours that families use to maintain contact and share in the physical, emotional, social and economic care of their relatives.

2) Family-those relatives or significant others with whom the resident maintains relationships.

3) Residents-those individuals who have lived in a LTC Facility for at least six months.

Assumptions

1) Residents value having relations with family maintained following admission to a LTC Facility.

2) Families vary in the type of support they provide their relatives.

3) The composition of families changes with time and the significant family members may not be immediate family members.
4) Residents who have lived in a LTC Facility for six months no longer experience relocation adjustment.

Limitations

This study recognized the following limitation:
The location of the study was limited to one LTC Facility in Vancouver. Therefore, specific characteristics of this setting and subjects in this institution may influence the type of activities that families are able to have with their relatives.

Overview

Chapter One has introduced the problem and the purpose of this study. A review of relevant literature appears in Chapter Two and the research methodology is described in Chapter Three. The analysis of data and the findings pertinent to the research questions are presented in Chapter Four. Chapter Five presents a summary, findings, conclusions, and implications and recommendations.

CHAPTER TWO

Literature Review

Introduction

The purpose of this chapter is to review literature pertinent to this study. The literature review is divided into the areas of family relationships and the elderly, the impact of placement on family members and the role of family members after placement of their elderly relative. A summary of the findings will conclude the chapter.

Family Relationships and the Elderly

In modern industrial societies a modified extended family structure exists which includes older family members (Troll, 1971). These modified extended families are usually formed from two, three or four generation nuclear units. For example, nuclear units might be composed of a young couple raising their children, a middle-aged postparental couple, an old retired couple, and a very old widow. A modified extended family structure develops from these nuclear units through residential propinquity, and social exchanges such as visiting and mutual aid involving services, advice and financial help (Litwak, 1959-60; Sussman, 1979; Sussman & Burchinal, 1962).

The exchange of aid among family members may be between parents and children, siblings, or more distant relatives such as

nieces and nephews and cousins. Exchanges between parents and their married children usually include services such as shopping, escorting, care of children (babysitting, boarding of grandchildren), counselling and advice-giving, recreation, home decorating, garden and yard work and home construction.

Exchanges of financial aid usually flow along generational lines, from parents to young married children and from middle-aged parents to aged parents (Sussman & Burchinal, 1962). Financial aid from parents to children may be in the form of goods such as furnishings, equipment, the use of a summer cottage, or transfer of property; money (education, low interest loans, subsidized visits and vacations) or occasionally as services (babysitting, redecorating, yard work). There is usually a considerable inbalance in the exchange of financial aid, with older members making a substantial contribution to younger family members (Harris, 1976; Tibbitts, 1979). Although many parents express the hope that they won't have to ask their children for help in their old age, it is possible that the pattern of giving to children is a subtle way of buying kinship insurance during the period of old age and senescence (Sussman, 1965). It has been estimated that only one percent of the elderly's children contribute significantly to their parents financial care (Peterson, 1979).

Social activities are important functions of modified extended families. Family get togethers and joint recreational activities with kin dominate leisure-time pursuits of urban working class families

(Sussman, 1965). Whether for social reasons or for the exchange of mutual aid, most elderly people maintain contact with their families and kin networks (Cogswell, 1975; Marciano, 1975; Rosenmayr, 1977; Shanas, 1979a, 1979b; Sussman, 1975). Studies in Denmark, Britain and the United States reveal that over 50% of the elderly had seen one of their children "yesterday or today". An additional quarter of the elderly saw a child two to seven days previously, while the remaining 23% had not seen a child for more than eight days. This same study found that of the elderly with no children 55% had seen a sibling or other relative during the previous week, while only 5% had no siblings or other relatives (Townsend, 1968).

Frequently included within the family are those non-kin individuals who are significant friends and whose relationships are as family to the elderly. Ball describes these close friends as "fictional relatives" (1972, p. 300) who are adopted into the family as members and assume obligations and affectional ties similar to other family members.

The importance of family members to the elderly is supported by Disengagement Theory. This theory recognizes that the elderly reduce contacts outside the family while contacts with their spouses, children, grandchildren, siblings and other relatives become more important (Troll, Miller, & Atchley, 1979). Those elderly persons who have had substantial involvement in kin family networks through the years, even though removed at times due to occupational and social

mobility, usually try to restore family ties in later years. Elderly individuals with a poor record of kin network activities may also work at reconstituting close family relationships (Sussman, 1976). Meaningful participation in a family group is important to the well-being of the aged, providing a major activity, involvement with other persons, and interests beyond their own personal life (Adams, 1971; Sussman, 1976).

The family has been identified as the first resource for support of elderly relatives, providing substantial physical, emotional, social and economic support (Brody, Poulshock & Masciocchi, 1978; Shanas, 1979a, 1979b). Family members who maintain supportive relationships with their elderly relatives may provide a home, or assistance in the form of shopping, banking, help with household tasks, crisis intervention during illness, and a hedge against organizational bureaucracies. Through family network activities and exchanges, family members provide intimacy and human warmth, both requisites for the survival and quality living of elderly family members (Shanas, 1979a, 1979b; Silverstone, 1979; Sussman, 1976; Townsend, 1957).

At one time it was felt that families "dumped" their elderly relatives in institutions. This has not proven to be so (Brody, 1977). Institutionalization usually results after prolonged and strenuous efforts by adult children to care for parents. In the United States long-term parent care has become a normative experience for

families (Brody, 1985). Adult children provide elderly relatives with more care, of greater difficulty, and for longer periods of time, than they did in the past. When adult children are not available for help, siblings in close proximity to each other often provide mutual support (Rosencranz, Pihlblad & McNevin, 1968; Troll et al., 1979). Statistics in the United States show that for every disabled person who resides in a nursing home, two or more equally impaired elderly live with and are cared for by their families (Comptroller General of the United States, 1977). In spite of the efforts of family members and the support of community agencies, there are times when placement in a LTC Facility is necessary to meet the needs of the elderly individual. At other times, placement in a LTC Facility may be the first choice for care by an elderly person who does not want to be a burden to family members or does not have close relatives. When the decision for placement in a LTC Facility is made, both the elderly and their family members are faced with a difficult period of adjustment as familiar roles are changed and new ways of seeking and providing support are developed.

The Impact of Placement on Family Members

Whether the decision to enter a facility is made independently by the elderly relative or in consultation with family members, residential uprooting is almost invariably upsetting. It results in a period of transition in which the institutionalized individual

undergoes many changes. The adjustment period from residential uprooting or long-stay hospitalization has been equated to bereavement, or marital separation, but in a less intense form (Weiss, 1979). An individual goes through a transition state involving one's emotional organization as well as his or her other relational arrangements. In addition to having to cope with new problems, the individual must find new ways of dealing with upsets and tension, and find new sources of support for security, feelings of worth, and for other components of well-being. Old relationships may no longer be appropriate, while new ones may need to be established. An individual's interests and goals may change and with them the sense of self. Typical responses to this stressful situation include depression, restlessness, and tendencies toward impulsive and irrational behaviour (Weiss, 1976).

For many elderly with declining physical, mental and economic resources "admission to a long-term care facility often represents a forced choice-a painful trade-off, where security is purchased at the cost of a further reduction in autonomy" (Ryden, 1984, p.130). Many elderly symbolize institutionalization as the ultimate loss of independence, leading to feelings of lowered personal worth and loss of self esteem (Mason,1954; Ryden, 1984; Silverstone & Hyman, 1976). Contributing to feelings of powerlessness are the decison by others that the elderly person should be institutionalized, the removal of self-administered medications, prohibitions or

limitations on alcoholic beverages, cigarettes and certain foods, and the loss of options regarding rising and bed times, bath times, mealtimes and menus (Brody, 1973).

Many elderly persons may have difficulty with the adjustment to a LTC Facility. A crisis may be precipitated by the acute stress of the admission (Brody & Spark, 1966). Residents frequently express feelings of abandonment, rejection, isolation and rage which can modify the course of chronic disease already present. The disability, pain and suffering which result may be used as a weapon by the aged person to retaliate against their children (Savitsky & Sharkey, 1972).

Sometimes residents of a nursing home are unable to recognize or admit openly that they feel rejected by family members and society, and are angry as a result of this rejection. Rather than act out their feelings of anger and rejection on staff who they need and cannot risk losing, they may act out their feelings of anger on student nurses who they know are not at the LTC Facility on a permanent basis (Carter & Galiano, 1981).

For their children, the institutionalization of a parent is described as "a nadir of life" and "one of the most unhappy times in the life of any human being" (Cath, 1972, p. 25). The crisis period affects family members in a number of ways. The period of preinstitutionalization is fraught with unhappiness as family members grieve over the loss of their parents' physical and mental capabilities, assume an increasing burden for their care, and stall the decision of

institutionalization. Relationships between family members may become stressed to the breaking point as they experience feelings of depression and despair and a mixture of rage and self reproach at the realization of what the decision must be.

When institutionalization occurs, family members experience anxiety, and agitation as they wonder what they have done to their parent. Although relieved of the immediate burden of care, families may also experience feelings of guilt, depression, loss and role conflict (Sancier, 1984; Savitsky & Sharkey, 1972; Silverstone & Hyman, 1977; Smith & Bengtson, 1979). Family members often experience the thought that this is a final move for their parent, and may feel that they have "put him away to die" (Cath, 1972, p.33).

It is important to prepare residents and their families for admission to an institution (Weiss, 1979; Wells, 1979). In general, the stress on the elderly of relocation to an institution can be reduced by preparation for the move, by moving to a similar or better environment and by ensuring that contact is maintained as long as possible with the community and the family (George, 1980). The reduction of negative feelings about placement is important because residents who exhibit more negative feelings about placement score higher across all factors for anticipated problems in nursing homes (Stein, Linn, & Stein, 1985). Adult children can benefit from having information about resources and agencies before placement; from having professionals provide instruction in care and coping skills; and

from the support of a group with which they can share feelings, experiences, and receive encouragement (Hatch & Franken, 1984).

The need for support of elderly residents and their families continues after institutionalization (Hatch & Franken, 1984; Weiss, 1979). Support groups can encourage discussion of ways to deal with changing roles and difficult emotions, as well as providing a means for educating family members about the important ways they can continue to be involved with their elderly relatives (Sancier, 1984). Because of their many contacts with the elderly and their families, nurses are in a unique position to provide assistance and support to the elderly and their families prior to, during and after institutionalization.

The Role of Family Members After Placement

Family members have an important role in the well-being of their relatives after placement. While the institution takes over the physical tasks of care, the family is the best source for emotional and social support of the resident (Portnoi, 1984). The daily presence of families and friends from the outside, their participation in providing care, and their continued support ensure that the resident "is neither segregated from the people who were, and are, important to her, nor from the community of which she was a member" (Dobrof, 1981, p. 46). Relatives can encourage the elderly to maintain their independence and do as much self care as possible, in spite of the fact

they may feel they are too sick or too old to do so. They also have an important role in providing information to facility staff about their elderly relatives likes, dislikes and special interests which allows staff to personalize care, thus contributing to a more homelike atmosphere.

Ideally there should be a balance between the tasks done by the formal organization of the facility staff and the resident's family, so that they can share care for the resident without subverting each other's role (Litwak & Meyer, 1966). Dobrof (1976) supports this concept of "shared function". In a study of 247 subjects in five facilities, Dobrof reports that families acted in ways that were complimentary to the activities of facilities. Families provided goods and services which raised the level of care provided by the facilities and provided services that met special needs and desires of their relatives.

Studies show that incorporating family members into the services offered to their institutionalized relatives actually assists in improving relations between the resident and their family (Dobrof, 1976; Dobrof & Litwak, 1977; Smith & Bengtson, 1979). In open-ended interviews over a period of two years with one hundred residents, Smith and Bengtson (1979) report responses in six categories: renewed closeness and strengthening of family ties (30%); discovery of new love and affection (15%); continuation of closeness (25%); continuation of separateness (20%); quantity without quality

interaction (10%); and abdication: institutions as a dumping ground (0%). The authors conclude that "the most predominant patterns of relations between residents and their families were those of renewed and strengthened closeness and a continuation of family closeness" (p. 444). One reason for improved closeness between family members and their elderly relatives after institutionalization is that relatives are freer to provide the psychosocial and emotional aspects of care.

Fourteen tasks or activities that are performed by the families of elderly residents have been identified (Dobrof, 1976). These activities constitute the social exchanges that families use to provide support for their institutionalized relatives. They include visits to the elderly resident; phone calls; letters; cards on special occasions; gifts of money; food treats; provision of small necessities; gifts such as clothing, jewellry, and plants; other provisions above institutionally defined minimum such as a telephone, television, and furnishings; shopping; errands; personal care such as feeding and mending clothes; special excursions to restaurants, movies, the theatre and church; and taking the elderly person to relatives' homes for special events and visits.

Visiting by relatives serves a number of purposes. It allows family members to keep in touch and provide emotional support to each other; helps to eliminate feelings of being abandoned; provides symbolic evidence to other family members, to the elderly relative, to the staff at the facility and to other residents and their families

of family responsibility and devotion; and provides opportunities for the discussion and exchange of advice about matters of concern about the family. Visiting also facilitates exchanges such as the sharing of special foods and monitoring the care elderly family members receive (Barney, 1972; Dobrof, 1976; Silverstone & Hyman, 1976).

Phone calls have been identified as a form of social exchange that maintains the accustomed pattern of contact between family members and their elderly relatives. For example, if family members are in the habit of calling their elderly relatives after breakfast, work or at bedtime, this pattern of contact can continue after institutionalization. Another benefit of the telephone is that the elderly person can call a family member to discuss something that he or she might forget before the next visit. Phone calls also provide the opportunity for residents and their families to assist each other with tension management. When upset or anxious about family matters or concerns about life in the LTC Facility, relatives can use the phone to discuss concerns with each other. For families who are geographically separated, a phone call may be the only type of personal contact that is possible between them. Phone calls also permit contact between the elderly and those more distant relatives who do not visit with them, but who express support and availability in case of need (Dobrof, 1976; Moss, Moss & Moles, 1985).

Letters, holiday and greeting cards are social exchanges that also help to maintain accustomed patterns of contact between the elderly

and their relatives. They are forms of social exchange that can be savoured, stored for future reference, and read and reread. For that reason they are particularly valuable to residents who are becoming forgetful. Letters and cards often contain pictures and newspaper clippings with news of old neighborhoods and friends, and they provide many residents with opportunities for reminiscence. Like telephone calls, letters and cards augment the contact of visits and bridge the miles for those who are geographically distant (Dobrof, 1976; Moss et al., 1985). Holiday and greeting cards may also be viewed as a symbol of family devotion in the social environment of the institution, as they provide an overt display of family support to staff, other residents and their relatives. Dobrof reports (1976) that some families who had not exchanged greeting cards before their relative was institutionalized began to do so after placement. For those relatives geographically removed from their elderly family members and unable to visit regularly, contacts such as phone calls, letters, greeting cards, photographs and newspaper clippings help to maintain family ties (Silverstone & Hyman, 1976).

The provision of food treats, the purchase of small necessities, and the provision of items such as a television or radio are exchanges of tangible items between families and their elderly relatives that contribute to raising their quality of life. These exchanges allow families to cater to the preferences of their relatives and to offer them more choices in their lives. For example, the gift of a television

is an acknowledgement of the fact that the elderly resident enjoys watching television, and it gives the elderly person the choice of watching programs with fellow residents in the common lounge or watching a program of choice in his or her own room. Gifts of special foods represent exchanges directed at maintaining a semblance of accustomed eating patterns and are used as opportunities to express love and emotional support (Dobrof, 1976). Gifts such as jewellry, room decorations and other items of importance to elderly relatives permit family members to contribute to the individual interests and identity of their relatives.

The performance of tasks for elderly relatives is an exchange in the form of service performed. Performing personal services allows relatives the opportunity to show continued devotion while services such as shopping, mending and running errands allow the elderly to maintain previous life styles.

There is potential for improving the morale of residents with low morale by using interventions that increase their perception of situational control (Longer & Ruden, 1976; Mercer and Kane, 1979; Ryden, 1983; Schultz, 1976). Caregivers who offer choices to residents, such as in the types of activities they participate in together, and who communicate a belief in the right of the resident to be self-directed give residents a perception of control.

Summary

A review of literature shows that the modified extended family provides important support to elderly members of the family. Whether the elderly live independently, with relatives, or in a LTC Facility, family members provide support to them through a variety of social exchanges.

Although literature indicates the importance of a perception of control to an individual's sense of well being, there is little literature documenting the wishes of the elderly about their care. It is important to know the views of elderly residents about the support given to them by their family members in order to advise families and residents, and to plan care and support that is in keeping with these wishes.

CHAPTER THREE

Research Design

Overview

The methodology that was used in this study had an exploratory descriptive design. Data was collected using a survey questionnaire. Kerlinger (1964) suggests that survey research is an efficient and effective method for collecting a large amount of accurate data and identifying interrelations among variables.

Variables

The independent variables in the study were the residents' demographic factors. The dependent variables were the activities performed by the families which were valued by the residents.

Data Collection Instrument

The instrument used in this study was a modification of the Questionnaire for Resident/Patient (see Appendix A) designed by Rose Dobrof (1976) for her Doctor of Social Work Dissertation, The Care of the Aged: A Shared Function. It was designed to measure fourteen activities that are performed by families in order to maintain contact and share in the care of their institutionalized relatives. The activities include visiting residents; phoning; corresponding by letter;

sending cards on special occasions; giving gifts of money; food treats; small necessities; gifts such as clothing, plants, or jewelry; giving other provisions above institutionally defined minimum (e.g. private telephones, television sets, furnishings); shopping; running errands (e.g. clothes to cleaners, repair of shoes, glasses, radios); providing personal care (e.g. feeding, mending of clothes, grooming); taking the resident on special excursions (e.g. to restaurants, movies, car rides, and sight-seeing); and taking the resident to relatives' homes for visits and special family events.

Permission was given by Dobrof to adapt the questionnaire (see Appendix B). The questionnaire was revised in order to: (1) exclude one question which identified subjects by name; (2) exclude questions about colour, race, and occupation; (3) reduce the number of questions about grandchildren and great-grandchildren and the age of relatives by clustering the information; (4) change terminology and names to reflect Canadian health care terminology and the names of local communities; and (5) include eight open-ended questions about the activities with relatives that are valued by subjects. The modified questionnaire consisted of forty-two questions.

Ethics and Human Rights

Permission to conduct this study was obtained from the manager of a LTC Facility in Vancouver (see Appendix C) and from the University of British Columbia Behavioural Sciences Screening

Committee for Research and Other Studies Involving Human Subjects. Permission to use the Questionnaire for Resident/Patient was received from it's designer, Rose Dobrof .

Subjects were given an information letter (see Appendix D) as well as a verbal explanation of the purpose of the study, and were asked to sign a consent form (see Appendix E) . A copy of the consent form was given to the participants. All subjects were informed that their participation in the study was voluntary, that it would involve completing a questionnaire, and that it would take approximately thirty minutes of their time. They were told that they could refuse to answer questions or could discontinue the study at any time without prejudicing their future medical or nursing care. Subjects were told that all information was confidential; that their names would not appear on the questionnaire or in the study; and that questionnaires would be destroyed after the information was analyzed.

Validity and Reliability

Validity refers to the degree to which a tool measures that which it is intended to measure (Polit & Hungler, 1983). There are a number of ways to establish the validity of a tool. Dobrof (1976) indicated that her knowledge of the residents and their families gained over many years of working with them, and her knowledge of the circumstances of their institutionalization provided an informal standard for preliminary assessment of the validity of the data

collected. In statistical terms, the finding of congruence in 79% of the cases, between the residents and relatives's description of who performed what tasks and with what degree of frequency can be taken as evidence of the validity of the information. In Dobrof's study many of the residents interviewed were diagnosed as moderately impaired mentally, thus accounting for some of the incongruence of results and strengthening the case for validity of the instrument (Dobrof, 1976).

Content validity of an instrument is based on judgment (Polit & Hungler, 1983). The questionnaire for Resident/Patient has content validity as the fourteen tasks included by the author as typical family activities were validated in discussion with administrators, social service directors and line staff, and nursing personnel in nursing home institutions.

Face validity exists when it is apparent that the questionnaire is relevant to what the researcher is trying to measure (Sellitz, Wrightsman & Cook, 1976). The Questionnaire for Resident/Patient was designed to measure the tasks performed by families in order to maintain contact and provide support for their institutionalized relatives. The questionnaire has face validity for this study as it measures the activities with family members that could be valued by residents of a LTC Facility.

The reliability of an instrument is the degree of consistency with which it measures what it is supposed to be measuring (Polit & Hungler, 1983). The Questionnaire for Resident/Patient was pre-

tested by Dobrof with a sample of ten residents. In addition, separate interviews were held with subjects and members of their families. Agreement between the subject and family was striking, with a congruence of 79% (Dobrof, 1976).

Setting

A LTC Facility of convenience was chosen as the setting for this study. The LTC Facility is in Vancouver, B.C. and has 240 residents who are assessed as Personal or Intermediate Care. When assessed at the Personal Care level an individual is considered to be independently mobile with or without mechanical aids and requires non-professional assistance or supervision with the activities of daily living (Ministry of Health, 1985). Intermediate Care recognizes individuals with increasing levels of disability who require daily professional care and/or supervision but can transfer independently (Ministry of Health, 1985).

Subject Selection and Sampling Techniques

Subjects included in the study met the following criteria:

1. They had lived in a LTC Facility for at least 6 months.
2. They had interaction in some form with a family member.
3. They were mentally and physically capable of understanding and answering questions in English.
4. They were not suffering from relocation stress.

A sample of approximately fifty subjects was selected randomly. The names of those subjects identified by the Director of Nursing as meeting subject selection criteria were placed in a box. One name was drawn from the box, recorded, and returned to the box. The procedure was repeated until fifty names had been drawn. The subjects whose names had been drawn were given a letter of information about the study by the facility nursing staff and asked to indicate if they were willing to participate in the study. If sufficient subjects were not obtained, additional names were drawn in the described manner and contacted as above until fifty subjects were obtained.

Data Collection Procedure

Subjects who met the criteria were identified by the Director of Nursing. The nursing staff gave the subjects a letter of information prepared by the researcher outlining the purpose, nature and implications of the study. If the subjects indicated a willingness to participate in the study, their consent was obtained and they received a copy of the consent form. The researcher then contacted them by telephone to arrange to meet with them individually in their rooms, at designated preset times. At that meeting, the ethical concerns of confidentiality, the right to refuse to answer questions, and the right to withdraw from the study at any time without jeopardizing care at the facility were explained by the researcher. After all questions

about the study were answered the researcher assisted the subject to complete the questionnaire. Completing the questionnaire took approximately one half an hour of the resident's time. Data for this study were collected over a two week period.

Data Analysis

Data from the questionnaires were quantified, then coded and placed on a computer file. To answer research question one (Which activities with family members do residents value?) descriptive statistics with frequency distributions, measures of central tendency and dispersion were used to analyze data. Tables were used to reflect frequency tabulations and percentages. To answer research question two (Is there a relationship between demographic characteristics and valued activities?) data was crosstabulated and then either the Cramer's V or Phi measures were applied to identify strengths of association. For the 2 X 2 table Cramer's V is also called Phi, and is identical to the square of the Pearson correlation coefficient obtained by assigning numeric scores to the rows and to the columns (Agresti, 1984). The Phi calculation was applied to the data when the crosstabulations involved a 2 X 2 table, otherwise Cramer's V was used. These measures give results falling between 0 and 1, with larger values representing stronger associations. Polit and Hungler support this type of analysis, stating that "descriptive studies whose goal is to depict the status quo of some situation typically have some

broader purpose in mind....These studies go beyond pure description; they deal with relationships" (1983, p. 134).

CHAPTER FOUR

Presentation and Discussion of Findings

Overview

A total of 55 residents who met the sampling criteria were asked to participate in this study. Five residents refused for a variety of reasons. All of the subjects who agreed to participate in the study completed the questionnaires, although not all of them answered every question. The results of this study are presented in three sections. The first section provides demographic and descriptive information about the subjects and their families. The second section provides descriptive information about the social exchanges that occur between the subjects and their family members. Section three provides the results of an analysis to ascertain whether there are associations between the demographic characteristics of the subjects and their families, and their valued social exchanges.

Demographic and Descriptive Information

The Residents

Table 1 presents a summary of the subjects according to Level of Care. Forty of the subjects (80%) are assessed as Personal Care,

Table 1

Level of Care of Subjects

Level of Care	Frequency N=50	Percent	Cumulative Percent
Personal Care	40	80	80
Intermediate I	9	18	98
Intermediate II	1	2	2

9 (18%) as Intermediate Care I, and 1 (2%) as Intermediate Care II according to the criteria of the British Columbia Long Term Care program (Ministry of Health, 1985).

Table 2 presents a summary of the medical diagnoses of the subjects arranged in diagnostic groups. All of the subjects reported at least one chronic medical condition, while 34 reported more than one. These findings reflect the criteria for eligibility for care under the British Columbia Long Term Care Program which include the requirement that clients have a chronic medical condition (Ministry of Health, 1985). The subjects' cumulative responses revealed that the medical conditions reported most frequently were of a musculoskeletal (21.4%), cardiac (16.7%) and digestive (16.7%) nature.

Table 2

Medical Diagnoses of Subjects Arranged in Diagnostic Groups

Diagnostic Grouping	Number of Responses n=84	% of Total Responses
Musculoskeletal	18	21.4
Cardiac	14	16.7
Digestive	14	16.7
Neurological	9	10.7
Peripheral vascular	7	8.3
Cancer	5	6.0
Visual	5	6.0
Endocrine/metabolic	4	4.8
Respiratory	3	3.5
Anemia	3	3.5
Memory Loss	1	1.2
Genitourinary	1	1.2

Note. N=50

Identifying Information

Table 3 presents a summary of the ages of the subjects arranged in 5 year age groups. The subjects ages ranged from 67 to 98 years. The mean age was 82.7 years and the median age 84 years. According to the 1981 census, there were 133,015 people over 65 in Vancouver and they had a mean age of 74.33 years (Statistics Canada, 1982). Although considerably older than their cohort group in Vancouver, the subjects' ages are typical of the ages of residents in other LTC Facilities. For example, in the New York study in which the original

Table 3

Ages of Subjects Arranged in 5 Year Age Groups

Age	Frequency N=50	Percent	Cumulative Percent
65-69	3	6.0	6.0
70-74	5	10.0	16.0
75-79	6	12.0	28.0
80-84	14	28.0	56.0
85-89	15	30.0	86.0
90-94	5	10.0	96.0
95-98	2	4.0	100.0

Questionnaire for Resident/Patient was used, the mean age of subjects was 82.8 years and the median age was 84 years (Dobrof, 1976).

Table 4 presents a summary of the subjects according to sex. Forty-four of the subjects (88%) were women and 6 (12%) were men. In the City of Vancouver in 1981, women constituted 63.9% of the cohort group aged 65 and over, while men constituted 36.1% (Statistics Canada, 1981). Although women outnumber men in the total aged cohort, the magnitude of the difference is particularly great in LTC Facilities. The higher risk of widowhood for women and the close association between widowhood and institutionalization in later years, accounts for the difference between the female/male ratio in subjects from LTC Facilities when compared to their cohort in the community (Dobrof, 1976).

Table 4

Sex of Subjects

Sex	Frequency N=50	Percent	Cumulative Percent
Male	6	12.0	12.0
Female	44	88.0	100.0

Table 5 presents a summary of the subjects by marital status and sex. Thirty-seven of the subjects (74%) were widowed , 8 (16%) were single, 4 were married (8%) and 1 (2%) was separated. These figures are inconsistent with the 65 and over cohort group in Vancouver where in 1981, only 35.4% were widowed, 7.5% were single, 53.8%

Table 5

Marital Status of Female and Male Subjects

Marital Status	Frequency N=50	Percent	Cumulative Percent
Widowed			
Female	34	68.0	68.0
Male	3	6.0	74.0
Single			
Female	7	14.0	88.0
Male	1	2.0	90.0
Married			
Female	2	4.0	94.0
Male	2	4.0	98.0
Separated			
Female	1	2.0	100.0
Male	-	-	-

were married and 3.3% were separated or divorced (Statistics Canada, 1982). Of the 37 widowed subjects, 92% were women compared to 84% of the 65 and over cohort who are widowed and living in Vancouver (Statistics Canada, 1982).

Table 6 presents a summary of the length of stay of subjects in the LTC Facility. The length of stay of subjects varied from 6 to 124

Table 6

Length of Stay of Subjects in the LTC Facility

Months in Facility	Frequency N=50	Percent	Cumulative Percent
6-12	12	24.0	24.0
13-24	10	20.0	44.0
25-36	7	14.0	58.0
37-48	8	16.0	74.0
49-60	4	8.0	82.0
61-72	2	4.0	86.0
73-84	3	6.0	92.0
85-96	2	4.0	96.0
97-108	1	2.0	98.0
109-121	-	-	98.0
122-124	1	2.0	100.0

months (10 years, 4 months). The mean length of stay was 37 months (3 years, 1 month), and the median was 31 months (2 years, 7 months). It is interesting to note that 10 subjects (20%) have lived in the Facility for 5 years or longer. The length of stay of subjects in the LTC Facility is consistent with statistics from other LTC Facilities. In a New York study with 247 subjects, the mean length of stay was 4.105 years with a median of 3.00 years (Dobrof, 1976). According to one of the assumptions of this study, since the residents have lived in the LTC Facility for more than six months they should no longer be experiencing relocation adjustment. Within the literature, relocation adjustment is considered to end several months after admission to a facility (Yawney & Slover, 1973; Tobin & Lieberman, 1976).

Table 7 presents a summary of the religious background of the subjects. Forty of the subjects (80%) were protestant, 4 (8%) were catholic, and the remaining 6 (12%) represented other religious groups. There was no data in the literature to indicate that this type of mixed religious background would alter patterns of social exchange between the subjects and their families.

Table 7

Religious Background of Subjects

Religion	Frequency N=50	Percent	Cumulative Percent
Protestant	40	80	80
Other	6	12	92
Catholic	4	8	100
Jewish	-	-	100
Unknown	-	-	100

Living Arrangements at time of Application

Table 8 presents a summary of the residence of subjects at time of application to the LTC Facility. The majority of subjects, 38 (76%), were living in a private home (house or apartment) while 11 (22%) reported being in another institution or hospital, and 1 (2%) was living in a non-private household.

Table 8

Residence of Subjects at Time of Application

Residence	Frequency N=50	Percent	Cumulative Percent
Private Home	38	76.0	76.0
Institution or Hospital	11	22.0	98.0
Non-private House	1	2.0	100.0

Table 9 presents a summary of the geographic location of subjects at the time of application for placement. Forty-five (90%) of the subjects were from the Vancouver area and 5 (10%) were from outside Vanouver. Given these figures, it is likely that the majority of subjects have known someone locally with whom they may continue to have social exchanges.

Table 9

Geographic Location of Subjects at Time of Application

Location	Frequency N=50	Percent	Cumulative Percent
Vancouver	45	90.0	90.0
Outside Vancouver	5	10.0	100.0

Table 10 presents a summary of the living arrangements of the subjects prior to admission to the LTC Facility. Thirty-five of the residents (70%) were living alone at the time of application for placement while 15 (30%) were living with someone. This data suggests that the elderly who live alone are at the greatest risk for institutionalization.

Table 10

Living Arrangements of Subjects Prior to Placement

Living Arrangement	Frequency N=50	Percent	Cumulative Percent
Alone	35	70.0	70.0
With Someone	15	30.0	100.0

Table 11 presents a summary of the household composition of the subjects prior to admission to the LTC Facility. Of the 15 subjects who lived with someone prior to admission, just under half (7) lived with a spouse, 4 lived with a friend, 3 with relatives, and 1 with a paid companion. These subjects had established social exchanges with their relatives prior to admission to the LTC Facility.

Item number 10 on the questionnaire, also relating to living arrangements, was deleted. The subjects' responses to this item were incongruent with their previous responses.

Table 11

Household Composition of Subjects Prior to Placement

Household Composition	Frequency N=50	Percent	Cumulative Percent
Alone	35	70.0	70.0
Spouse	7	14.0	84.0
Friend	4	8.0	92.0
Daughter & family	1	2.0	94.0
Son & family	1	2.0	96.0
Siblings	1	2.0	98.0
Paid Companion	1	2.0	100.0

Table 12 presents a summary of the subjects who lived alone but had relatives or friends in the same building. The vast majority of those living alone did not have a close friend or relative in the building (65.7%) while the remaining 1/3 (34.2%) had relatives or friends living in the same building. Having friends and relatives in close proximity facilitates mutual support and social exchanges between family members and friends.

Table 12

Subjects Living Alone with Relatives in the Same Building

Relative or Friend	Frequency N=35	Percent	Cumulative Percent
Close Friend	10	28.5	28.5
Son and spouse	1	2.9	31.4
Other relatives	1	2.9	34.3
None of the above	23	65.7	100.0

Reasons for Admission to the LTC Facility

Table 13 presents a summary of the 83 responses reported by the 50 subjects regarding reasons for admission to the LTC Facility. Seventeen of the subjects (34%) reported only one reason for admission and 33 (66%) reported two reasons. Of the single responses, 25 (50%) reported "can't manage" and 11(22%) reported "poor health". The cumulative responses indicated that 66.2% of the responses were either "poor health" or "can't manage". These results reflect the large number of subjects with problems of a musculoskeletal and cardiac nature, the number who were in a hospital or other institution at the time of application, and the large number who were living alone. In addition, 2 of the subjects reported

Table 13

Reasons Given by Subjects for Placement in LTC Facility

Admission Reason	Frequency n=83	Percent of Responses
Poor health	30	36.2
Cannot manage	25	30.2
Family decision	5	6.0
Loneliness	5	6.0
Death of spouse	4	4.8
Other	3	3.6
Loss of apartment or home	3	3.6
Change in family status	2	2.4
Financial need	2	2.4
Fear of declining health	2	2.4
Changing neighborhood	1	1.2
Felt in the way	1	1.2

Note. N=50

fear of declining health status as their reason for admission. Four subjects gave the death of their spouse as their reason for admission to the LTC Facility, while 2 indicated a change in status of their family as their spouses were seriously ill and required hospital or facility care. These changes altered the patterns of support that had been established between the subjects and their partners. Four of the subjects indicated a changing neighborhood and loss of apartment or home as reasons for moving to the LTC Facility. Nine residents indicated "other" as their reason for admission to the LTC Facility. Of these, 5 indicated that it was their families' decision that they be placed in a LTC Facility, 3 did not give a reason, and 1 indicated feeling in the way at a child's home. The responses indicating the decisions for placement were made by families, rather than by the residents, reflects the position of powerlessness that some of the elderly may be in (Brody, 1985).

Family Composition

Table 14 presents a summary of the responses of the 27 subjects about their surviving children. Twenty-seven (54%) of the subjects reported having surviving children. Of these, 23 reported having at least one son and 14 reported having at least one daughter. Twenty-three subjects (47%) did not have surviving children. It is interesting to note the high number of subjects with no surviving children, considering that only 8 of the subjects had never married.

Since children are acknowledged as being one of the major sources of support for their elderly parents (Shanas, 1979b), the high number of subjects without children may have been a factor contributing to their institutionalization.

Table 14

Surviving Children of Subjects

Surviving Children	Frequency n=60	Percent of Responses
none surviving	23	38.3
son (s)	23	38.3
daughter (s)	14	23.4

Note. N=50

Table 15 presents a summary of the number of subjects who have grandchildren and greatgrandchildren. Twenty-three of the subjects (46%) have surviving grandchildren and 15 (30%) have greatgrandchildren. This data is of interest since the grandparent role, although not significantly related to general life satisfaction, is still very meaningful and a great source of personal satisfaction to many older people. For those grandparents who enjoy the role it is important for them to maintain social exchanges with their

grandchildren (Troll et al., 1979).

Table 15

Subjects with Grandchildren and Greatgrandchildren

Relative	Frequency N=50	Percent
Grandchild		
Yes	23	46.0
No	27	54.0
Greatgrandchild		
Yes	15	30.0
No	35	70.0

Table 16 presents a summary of the number of subjects who have siblings. Thirty-one of the subjects (62%) in this study have surviving siblings. This figure is much lower than that reported in the literature. A 1975 study involving a national sample of people 65 and over in the United States indicated that 79% had siblings (Harris & Associates, 1975). Another study reported that 6 out of 7 women over 65 have living siblings (Shanas et al, 1968). The relatively high mean age (82.7) of this subject group and the death of some siblings due to their advanced age, could be reflected in the low percentage of

study subjects with siblings. Siblings play a very important role in the lives of the elderly. In many instances the elderly participate in as many social exchanges with their siblings as they do with their children (Parron, 1978).

Table 16

Subjects with Siblings

Surviving Sibling	Frequency N=50	Percent	Cumulative Percent
Yes	31	62.0	62.0
No	19	38.0	100.0

Table17 presents a summary of the subjects with nieces and nephews. Thirty-five of the residents (70%) reported having nieces or nephews. One resident did not respond to this question. Nieces and nephews are an important source of support to the elderly, often performing activities and tasks that children and grandchildren do. For the elderly who have never married, or for those who married but do not have children, nieces and nephews often assume tasks usually performed by children (Troll et al., 1979).

Table 17

Subjects with Nieces and Nephews

Nieces or Nephews	Frequency N=50	Percent	Cumulative Percent
yes	35	70.0	70.0
no	14	28.0	98.0
missing	1	2.0	100.0

Family Availability

Table 18 presents a summary of the availability of family members. The 50 subjects indicated they had 175 family members or significant others. Sons and daughters together accounted for 25.7% of the available relatives, as did nieces and nephews (25.7%). They were closely followed by siblings (23.4%). The figures for surviving children are very low when compared to the noninstitutionalized population in the United States where 4 of every 5 noninstitutionalized persons over 65 have living children (Shanas, 1979a). It is interesting to note that in a New York study involving 247 residents from 5 LTC Facilities, the number of available sons and daughters (24.5%) and nieces and nephews (17%) was lower than in this study (Dobrof, 1976). The availability and involvement of

relatives with elderly residents reflects the findings of other studies that the modified extended family is the dominant family form for elderly persons in North America.

Table 18

Availability to Subjects of Family Members

Relative	Frequency n=175	Percent of Responses	Cumulative Percent
son	17	9.7	9.7
daughter	28	16.0	25.7
niece or nephew	45	25.7	51.4
sibling	41	23.4	74.8
grandchild	23	13.2	88.0
significant other	21	12.0	100.0

Note. N=50

Table 19 presents a summary of the distance relatives live from the subjects. Of the 175 family members reported, 34 (19.4%) live within 30 minutes of the subjects, 27 (15.4%) live in the Metropolitan Vancouver area but more than 30 minutes away, and 114 (65.1%) live outside the Metropolitan Vancouver area. A total of 34.8% of the subjects' relatives live in the Metropolitan Vancouver area. Of the 50

Table 19

Distance of Relatives from Subjects

Distance	Frequency n=175	Percent of Responses
outside Metro Vancouver	114	65.2
within 30 minutes	34	19.4
Metro Vancouver > 30 minutes	27	15.4

Note. N=50

subjects in the study, 38 (76%) reported having relatives in the Metropolitan Vancouver area while 12 (24%) had none. These subjects are similar to the 247 residents of 5 LTC Facilities in New York (Dobrof,1976) where 80% of the subjects had at least one relative in the Metropolitan New York area.

Table 20 presents a summary of the subjects' key relatives. Seventeen of the subjects (34.0%) reported that their key relative is their daughter. Following at a distance but closely grouped were: significant other -9 (18%), son-8 (16%), niece or nephew- 8 (16%), and sibling -7 (14%). Grandchild was cited in only 1 instance (2.0%). The high number of subject responses indicating daughter as key relative reflects the major role that daughters assume in caring for

their elderly relatives (Brody, 1985; Horowitz, 1982; Shanas, 1979b). The high number of significant others, nieces and nephews considered as key relatives probably reflects the large number of subjects in this study who have no children.

Table 20

Subjects' Key Relatives

Relative	Frequency N=50	Percent	Cumulative Percent
daughter	17	34.0	34.0
significant other	9	18.0	52.0
son	8	16.0	68.0
niece or nephew	8	16.0	84.0
sibling	7	14.0	98.0
grandchild	1	2.0	100.0

Physical Limitations of the Subjects

Table 21 presents a summary of the mobility of the subjects. Thirty-nine of the subjects (78%) indicated that their mobility is unlimited, while 11 (22%) are limited to the institution. Limitations in mobility can influence the social exchanges that subjects have with their family members. It was found that those residents who

are unlimited in their mobility, provided they have no other serious handicaps, are usually less dependent on their families for activities outside the institution (see Table 50).

Table 21

Mobility of Subjects

Mobility	Frequency N=50	Percent	Cumulative Percent
Unlimited	39	78.0	78.0
Limited to Institution	11	22.0	100.0

Table 22 presents a summary of the subjects' special handicaps. Thirty-eight of the subjects reported at least one handicap, 12 reported two, and 4 reported three. The special handicaps reported most frequently were gait (40.7%), blind or partially blind (31.5%), and deaf (18.5%). Other handicaps reported were memory problems and incontinence. Twelve of the residents (24%) did not feel they had any special handicaps. The high number of responses indicating problems with gait reflects the high number of subjects who had diagnoses affecting the musculoskeletal system (arthritis, back problems, and fractured hips). Problems with gait, blindness and deafness all have an impact on the type of social exchanges the

subjects can partipate in with their families.

Table 22

Special Handicaps of Subjects

Special Handicap	Frequency n=54	Percent of Responses
gait	22	40.7
blind or partial	17	31.5
deaf	10	18.5
other	3	5.5
memory problem	1	1.9
incontinence	1	1.9

Note. N=38

Social Exchanges between Subjects and their Families

The family's role in supporting their institutionalized elderly relative has been observed to include fourteen tasks or social exchanges. These tasks and the residents views about them will be discussed in the following section. Visiting has been identified as being of particular importance because of the variety of purposes it

serves and because of the way it is perceived by the elderly resident, the family and staff. Therefore, it will be analyzed in more detail than the other social exchanges.

Activities with Families

Visiting.

Table 23 presents a summary of the subjects' visitors. The 50 subjects gave a total of 111 responses regarding their different visitors. Of the total subject responses, significant other was reported most frequently (38 responses or 34.2%). Daughters were the group of relatives visiting most frequently (23 or 20.7%), followed by siblings (cumulative responses of brothers and sisters was13 or 11.7%), sons (12 or 10.8%), and granddaughters (10 or 9.0%). The high number of subject responses indicating significant other indicates that many of the subjects have a close friend who is considered as family to them. This likely reflects the high number of subjects who are either single, separated or widowed (92%). Amongst family members, the visiting linkage with relatives is generally stronger along the female line. This is reflected by the subjects responses indicating that daughters are the most frequent visitors and that granddaughters follow closely behind sons (Troll et al., 1979).

Table 23

Subjects' Visitors

Visitor Group	Frequency n=111	Percent of Responses
significant other	38	34.2
daughter	23	20.8
son	12	10.8
granddaughter	10	9.0
brother	8	7.2
grandson	6	5.4
sister	5	4.5
son-in-law	5	4.5
daughter-in-law	2	1.8
spouse	2	1.8

Note. N=50

Table 24 presents a summary of the frequency of family visits to subjects. Over 34% of the subjects reported having visits from family members at least once a week, 16.2% twice a month and 11.8% once a month. A total of 62.2% of the subjects have visitors at least once a month. These figures reflect an established pattern of social exchange with family members rather than a response to a short term family crisis. The frequency of visits is slightly lower than those reported in Dobrof's New York study (1976) where 70% of the subjects had visitors at least once a month.

Table 24

Frequency of Visitors to Subjects

Visitor Frequency	Frequency of Responses n=111	Percent of Responses
2 per week	12	10.8
1 per week	26	23.4
2 per month	18	16.2
1 per month	13	11.8
less often	42	37.8

Note. N=50

Table 25 presents a summary of the relatives with whom subjects would like more visits. Seven of the subjects reported that they would like their relatives to visit more often. One subject specified the daughter-in-law, 2 the sons-in-law, and 1 the grandchildren. The other 3 subjects did not specify which family member they would like to visit more frequently.

Table 25

Relatives with Whom Subjects Would Like More Visits

Who	Frequency N=7	Percent	Cumulative Percent
unspecified	3	42.9	42.9
son-in-law	2	28.7	71.6
daughter-in-law	1	14.2	85.8
grandchildren	1	14.2	100.0

Table 26 presents a summary of the subjects reasons why relatives cannot visit more frequently. Ten subjects responded to the question. When indicating why relatives did not visit more frequently, 7 subjects acknowledged that they had too far to travel

and 3 subjects gave additional reasons (family or business responsibilities, other, and no reason). Forty of the subjects did not respond to the question.

Table 26

Reasons Why Relatives Cannot Visit More Frequently

Reason	Frequency N=10	Percent	Cumulative Percent
too far	7	70.0	70.0
family/business responsibilities	1	10.0	80.0
other	1	10.0	90.0
no reason	1	10.0	100.0

Phone Calls.

Table 27 presents a summary of the relatives with whom residents have phone calls. The 50 subjects reported social exchanges in the form of phone calls involving a total of 103 sources. These calls were with daughters 23.3% of the time and with their sons 13.6% of the time. Together, sons and daughters accounted for 36.9% of the calls. It is interesting to note that 21.4% of the calls

were with significant other and 19.4% were with siblings. The number of responses (103) indicates that on the average, subjects have more than one relative or significant other with whom they participate in this type of social exchange.

Table 27

Relatives with Whom Residents Have Phone Calls

Relative	Frequency n=103	Percent	Cumulative Percent
daughter	24	23.3	23.3
significant other	22	21.4	44.7
sibling	20	19.4	64.1
son	14	13.6	77.7
niece or nephew	14	13.6	91.3
grandchild	9	8.7	100.0

Note. N=50

Letters.

Table 28 presents a summary of the relatives with whom residents exchange letters. Thirty-five of the subjects gave 59 responses regarding exchanging letters with family members. The largest number of letters were exchanged with significant other

(32.2%), children (22.1%), siblings (22%), nieces and nephews(16.9%), and grandchildren (6.8%). That only 35 subjects exchange letters with their relatives probably reflects the age of the subjects and their relatives. Their failing eyesight, joint pain, and mental orientation are factors that can make it difficult to write letters.

Table 28

Relatives With Whom Residents Exchange Letters

Relative	Frequency n=59	Percent	Cumulative Percent
significant other	19	32.2	32.2
sibling	13	22.0	54.2
niece or nephew	10	16.9	71.1
son	7	11.9	83.0
daughter	6	10.2	93.2
grandchild	4	6.8	100.0

Note. N=35

Cards on Special Occasions.

Table 29 presents a summary of the family members with whom

residents exchange cards. Forty-eight of subjects gave a total of 96 responses, indicating that they exchange cards most frequently with children (29.2%), significant other (25%), nieces or nephews (18.8%), siblings (17.7%) and grandchildren (9.3%). This high participation in social exchanges with cards for special occasions reflects the symbolic importance that cards have to family, residents and staff in an institutional setting (Dobrof, 1976).

Table 29

Relatives With Whom Subjects Exchange Cards

Relative	Frequency n=96	Percent of Responses
significant other	24	25.0
niece or nephew	18	18.8
daughter	17	17.7
sibling	17	17.7
son	11	11.5
grandchild	9	9.3

Note. N=48

Being Taken to Relatives' Homes.

Table 30 presents a summary of the relatives who take family members to their homes. Thirty-three of the subjects reported visits to 40 relatives. Their responses included 14 visits to daughters (35%), 7 to nieces or nephews (17.5%), 6 to others (15%), 6 to siblings (15%), 4 to sons (10%) and 3 to grandchildren (7.5%). That residents are taken more frequently to their daughters homes than to other relatives adds to the evidence from other studies (Brody, 1985; Horowitz, 1982; Shanas, 1979b) that daughters are the most supportive relative with family members.

Table 30

Relatives Who take Subjects to their Homes

Relative	Frequency n=40	Percent of Responses
daughter	14	35.0
niece or nephew	7	17.5
significant other	6	15.0
sibling	6	15.0
son	4	10.0
grandchild	3	7.5

Note. N=33

Outings with Relatives.

Table 31 presents a summary of the relatives who take subjects on outings with them. Twenty-eight subjects gave 38 responses regarding going out for drives, to restaurants, or on other outings with their relatives. Daughters and significant other were each cited 9 times (23.7%), nieces and nephews 6 times(15.8%), sons and grandchildren 5 times (13.2%) each, and siblings 4 times (10.5%). It is the daughters, and significant others who are most involved in taking the elderly subjects on outings.

Table 31

Relatives Who take Family Members on Outings

Relative	Frequency N=38	Percent of Responses
daughter	9	23.7
significant other	9	23.7
niece or nephew	6	15.8
son	5	13.2
grandchild	5	13.2
sibling	4	10.4

Other Social Exchanges.

Only one subject indicated other social exchanges that were of value. This subject indicated that going for walks and playing bridge were important ways to share time with relatives and have opportunities for providing mutual support to each other.

Activities With Relatives that are Most Valued by Subjects.

Table 32 presents a summary of the activities with relatives that are most valued by subjects. Forty-eight of the subjects responded

Table 32

Activities Most Valued by Subjects

Activity	Frequency n=66	Percent of Responses
visits	30	45.5
phone calls	23	34.8
letters	4	6.2
take to home	3	4.5
excursions	3	4.5
other	2	3.0
cards	1	1.5

Note. N=48

giving a total of 66 responses when asked to indicate which two activities they valued most with their relatives. The activities that were most valued were visits (45.5%) and phone calls (34.8%). Both of these activities provide personal contact between the elderly and their family members. As well, they fascilitate other exchanges, either directly (as in bringing special food treats) or indirectly (planning a visit or outing on the phone); and they are a means of tension reduction for residents and their families (Dobrof, 1976). There were no additional activities suggested by the subjects that might have been more valued.

Contact with Relatives.

Table 33 presents a summary of the subjects responses about having more contact with relatives. When asked if they would like

Table 33

Subjects Wishes Regarding Contact with Relatives

Like More Contact	Frequency N=50	Percent	Cumulative Percent
yes	8	16.0	16.0
no	42	84.0	100.0

more contact with their relatives, 8 subjects (16%) indicated yes and 42 subjects (84.0%) indicated no. These responses reflect previous data indicating 7 subjects (14%) would like to have specific relatives visit them more often (see Table 25). Of the 8 subjects who indicated they wanted more contact with their relatives, 2 wanted them to show more interest but did not indicate in what way they wanted to increase contact; 2 wanted more visits and 4 did not say in what way they wanted more contact.

Gifts.

Table 34 presents a summary of the gifts that subjects receive from their families. Forty-five of the subjects indicated that they receive gifts from family members. Gifts received most frequently are food treats (73.3%), clothes (60.0 %), and small necessities (44.4%). Other gifts include books, newspapers, and magazines; furnishings; spending money; payment of telephone bills; jewelry and miscellaneous items such as writing paper and listening tapes. Subjects in the New York study (Dobrof, 1976) also reported receiving food treats more frequently than other gifts. Unlike this study the provision of small necessities was the second most popular group of gifts, followed by clothing in third place. Gifts of clothing may have rated higher than usual in this study since the survey was conducted shortly after Christmas and small items of clothing are popular

Christmas gifts. However, it is also true that food (candy, nuts,and Christmas baking), books and radios are popular gifts at Christmas.

Table 34

Gifts from Family Members

Gift	Frequency n=141	Percent of Cases N=45
food treats	33	73.3
clothes	27	60.0
small necessities	20	44.4
books, newspapers, magazines	17	37.8
furnishings	15	33.3
other	10	22.2
spending money	9	20.0
radio, television	5	11.1
telephone bill	3	6.7
jewelry	2	4.4

Note. N=48

Table 35 presents a summary of the reasons subjects value gifts. When asked in an open ended question what it is about gifts that is of

value, twenty-seven of the subjects gave 31 responses. The majority, 17 (54.8%), responded that it was the thought that was of value to them. Two of the subjects indicated gifts were of value because of the caring they represent. Others mentioned that small personal family items (such as pictures) were of value; that gifts were a nice surprise, and that they provided extras for them. One subject responded that gifts were "too much" but did not elaborate on this comment. Six of the subjects (19.4%) indicated that they do not want

Table 35

Responses of Subjects Regarding the Value of Gifts

Reason Gifts Valued or Not Valued	Frequency n=31	Percent of Responses
the thought	17	54.8
do not want any	6	19.4
small personal family items	3	9.7
caring	2	6.5
extras	1	3.2
surprise	1	3.2
too much	1	3.2

Note. N=27

any gifts. It is interesting to note that none of these six subjects had children, nor did they have family members or significant others living within 1/2 hour of the LTC Facility.

Although not asked to do so on the questionnaire, many of the subjects made suggestions about gifts that would be suitable for residents of a LTC Facility. These suggestions included gift certificates for phone calls, hairdressing appointments, manicures, taxis, and luncheons; theatre and symphony tickets; items of clothing and plants.

Personal Assistance Activities.

Table 36 presents a summary of the personal assistance activities that relatives do with and for subjects. Thirty-five subjects gave a total of 86 responses about exchanges involving personal care activities with their relatives. The majority of activities involve shopping (34.9%), transportation to outside doctors and clinics (26.7%), running errands and taking things for repair (19.8%), and sewing (16.3%). Most of these activities reflect assistance that is required due to the decline that subjects have experienced in their physical conditions. Fifteen subjects did not respond to the question, indicating that they were quite independent and did not need help with these activities. All 15 of these subjects were assessed at the Personal Care level.

Table 36

Frequency of Personal Assistance Activities with Family

Activity	Frequency n=86	Percent of Responses
Shopping with or for	30	34.9
Transportation to appointments	23	26.7
Errands and repairs	17	19.8
Sewing	14	16.2
Reading to you	1	1.2
Take to activities in institution	1	1.2

Note. N=35

Table 37 presents a summary of the relatives who assist with personal assistance activities. In reporting which family members provide assistance with personal assistance activities, the 35 subjects gave 98 responses. The subjects' responses indicated that daughters (36.7%) and significant others (35.7%) provided the most help with personal assistance activities. All other relatives were far behind in their support with these activities.

Table 37

Relatives Who Partake in Personal Assistance Activities

Relative	Frequency n=98	Percent of Responses
daughter	36	36.7
significant other	35	35.7
niece and nephew	8	8.2
sibling	8	8.2
grandchild	8	8.2
son	3	3.0

Note. N=35

Table 38 presents a summary of the personal care activities that are most valued by the subjects. When asked if any of the personal assistance activities with family members were particularly valuable to them, 18 subjects gave 24 responses. The activities identified as most valuable were having transportation to doctors appointments and clinics (58.3%) and being taken shopping or having shopping done for them (37.5%). One subject identified having errands run and items repaired (4.2%) as being important. Requiring this type of assistance is consistent with the data indicating many subjects'

have problems of a musculoskeletal and cardiac nature (see Table 2), and that some have decreased mobility (see Table 21).

Table 38

Personal Assistance Activities Most Valued by Subjects

Activity	Frequency n=24	Percent of Responses
Transportation to outside doctors, clinics	14	58.3
Shopping with or for you	9	37.5
Errands and repairs	1	4.2

Note. N=18

Special Programs.

Table 39 presents a summary of the responses about whether families come to special programs at the LTC Facility. Eighteen of the subjects (36%) indicated that their relatives attend programs at the LTC Facility. The special luncheons and dinners, special occasion parties and dances at the LTC Facility provide residents with an opportunity to reciprocate for the support received from relatives and close friends, thus reducing the indebtedness they may feel in their balance of social exchanges.

Table 39

Family Attendance with Subjects at Special Programs

Family Attendance at Special Programs	Frequency N=50	Percent
yes	18	36.0
no	42	84.0

Change in Frequency of Family Contact.

Table 40 summarizes the responses of subjects regarding changes in contact with relatives since institutionalization. Eight of the subjects reported an increase in contact with their relatives since admission to the LTC Facility, while the other subjects reported their contacts were unchanged. None of the subjects indicated decreased contact with relatives. The increased contact with relatives is consistent with previous research studies that report enhanced family relations after institutionalization of the elderly (Montgomery, 1982; Smith & Bengtson, 1979).

Table 40

Changes in Family Contact Since Placement

Contact with Relatives	Frequency N=50	Percent
Increased	8	16.0
No change	42	84.0
Decreased	-	-

Table 41 presents a summary of the subjects responses about whether family members asked what activities they liked to do with them. Twenty-three of the subjects (46.0%) responded positively. More than half of the subjects reported not being asked about their preferred activities. Failing to ask residents for their opinion may unintentionally put the elderly into positions of powerlessness.

Most Supportive Activities.

Table 42 presents a summary of the activities with relatives that subjects find the most supportive and which provide the most contact. Forty-seven of the subjects gave 74 responses to this open

Table 41

Whether Family Asked Subjects about Favored Activities

Asked About Preferred Activities	Frequency N=50	Percent
yes	23	46.0
no	27	54.0

ended question. Three responses appeared on the questionnaires most frequently: phone calls (32.4%), visiting (24.3%), and being available (23.0%). Although visits were identified as the activity subjects valued most with their families (see Table 32), the subjects do not find them as supportive as phone calls. Seventeen of the subject responses indicated "being available" is supportive. This response is acknowledged by the researcher, but does not fall within the category of social exchanges identified and discussed in this study or in the New York study in which the questionnaire was first used (Dobrof,1976).

Table 42

Activities that Subjects find Most Supportive

Activities	Frequency n=74	Percent	Cumulative Percent
phone calls	24	32.4	32.4
visiting	18	24.3	56.7
being available	17	23.0	79.7
going to homes	4	5.4	85.1
letters	4	5.4	90.5
shopping	2	2.7	93.2
driving to places	2	2.7	95.9
looking after business matters	2	2.7	98.6
lunching out	1	1.4	100.0

Note. N=47

Facility Help to Maintain Family Contact.

All 50 of the subjects answered yes when asked if the Facility did everything it could to help maintain contact with families. When asked what more the Facility could do only one subject responded. This subject suggested delivering messages faster at the front desk.

Associations between Demographic Activities and Social Exchanges

An analysis was undertaken to determine whether there was an association between the demographic characteristics of subjects and their families, and the social exchanges that they participated in. In order to do this analysis, data were crosstabulated and then either the Cramer's V or Phi calculation was used to determine association. The Phi calculation was applied to the data when the crosstabulations involved a 2 X 2 table, otherwise Cramer's V was used. Both Cramer's V and Phi calculations produce results falling between 0 and 1, with larger values representing stronger associations. All results with a value of 0.5 or higher were considered to show a significant association. Significant correlations were found between the demographic characteristics surviving child and visits by daughter, visits by significant other, phone calls with daughter, exchange of cards with daughter and being taken to a daughter's home; and between level of care and personal assistance activities with significant other. Also of interest were the significant correlations between the demographic characteristics surviving child and key relative; and marital status and key relative.

Table 43 presents a summary of the crosstabulation of surviving child and visits by daughter. The association between surviving child and visits by daughter has a Phi value of 0.78540. The crosstabulation shows a high number of surviving daughters participate in social exchanges with subjects involving visits. This reflects the data that shows 34% of the subjects value daughters as their key relative (see Table 20), and that visiting is the social exchange activity that is most valued by subjects (see Table 32).

Table 43

Crosstabulation of Surviving Child and Visits by Daughter

	Visits by Daughter	
Surviving Child	Yes	No
Yes	21	6
	(42%)	(12%)
No	-	23
	-	(46%)

Table 44 presents a summary of the crosstabulation of surviving child and visits by significant other. The association between surviving child and visit by significant other has a Phi value of 0.63989. The crosstabulation shows that those subjects who have no surviving children have a large number of visits from significant others, while those who have surviving children have fewer visits with significant others. These results reflect the large number of subjects (see Table 14) who do not have a surviving child and the high value these subjects place on visits with a significant other (see Table 23).

Table 44

Crosstabulation of Surviving Child and Visits by Significant Other

	Visits by Significant Other	
	Yes	No
Surviving Child		
Yes	9	18
	(18%)	(36%)
No	22	1
	(44%)	(2%)

Table 45 presents a summary of the crosstabulation of surviving child and phone calls with daughter. The association between surviving child and phone calls with daughter has a Phi value of 0.80643. The crosstabulation shows that most of the subjects with daughters have phone calls with them. This data reflects the high value that subjects place on having social exchanges in the form of phone calls (see Table 32) as well as the value that they place on their relationships with their daughters (see Table 20).

Table 45

Crosstabulation of Surviving Child and Phone Calls with Daughter

	Calls with Daughter	
	Yes	No
Surviving Child		
yes	23	4
	(46%)	(8%)
no	-	23
	-	(46%)

Table 46 presents a summary of the crosstabulation of surviving child and exchange of cards with daughter. The association between the surviving child and the social exchange of cards with daughters has a Phi value of 0.66244. The crosstabulation shows that more than half of the subjects who have daughters exchange cards with them. These results reflect the study data showing that many subjects value this form of social exchange with their daughters (see Table 29).

Table 46

Crosstabulation of Surviving Child and Exchange of Cards with Daughter

	Exchange Cards with Daughter	
	Yes	No
Surviving Child		
Yes	17	10
	(34%)	(20%)
No	-	23
	-	(46%)

Table 47 presents a summary of the crosstabulation between surviving child and being taken to a daughter's home. The association between surviving child and the exchange of going to a daughter's home has a Phi value of 0.57557. The crosstabulation shows that just over half of the subjects with daughters reported going to their homes. These results reflect the study data showing subjects value being taken to their relatives homes (see Table 32) and the high value that they place on relationships with their daughters (see Table 20).

Table 47

Crosstabulation of Surviving Child and Being Taken to Daughter's Home

	Taken to Daughter's Home	
	Yes	No
Surviving Child		
Yes	14	13
	(28%)	(26%)
No	-	23
	-	(46%)

Table 48 presents a summary of the crosstabulation of level of care and personal assistance activities with significant other. The association between level of care and personal assistance activities with significant other has a Cramer's V value of 0.58286. Only 6 out of 40 subjects who were assessed as Personal Care indicated participation in personal assistance activities with significant others, while 8 out of 10 subjects assessed as Intermediate I and II participated in personal assistance activities with significant others.

Table 48

Crosstabulation of Level of Care and Personal Assistance Activities with Significant Other

	Personal Assistance Activity with Significant Other	
	Yes	No
Level of Care		
Personal	6	34
	(12%)	(68%)
Intermediate I	7	2
	(14%)	(4%)
Intermediate II	1	-
	(2%)	-

These figures show the increased dependence that subjects have as their level of care increases and reflect the value that subjects place on social exchanges involving assistance with personal care activities (see Table 36).

Table 49 presents a summary of the crosstabulation of marital status and key relative. The association between marital status and key relative has a Cramer's V value of 0.66423. The crosstabulation shows that single subjects tend to choose siblings, nieces, nephews

Table 49

Crosstabulation of Marital Status and Key Relative

	Key Relative					
	Son	Daughter	Grand-Child	Sibling	Niece or Nephew	Significant Other
Marital Status						
Single				2 (4%)	4 (8%)	2 (4%)
Married		3 (6%)				1 (2%)
Widowed	8 (16%)	14 (28%)		5 (10%)	4 (8%)	6 (12%)
Separated			1 (2%)			

and significant others as their key relative, while married and widowed subjects identify their sons or daughters as their key relative. These results provide evidence of the supportive role of the modified extended family. They also reflect demographic data showing the marital status of subjects (see Table 5) and showing that daughters, significant others, sons, nieces, nephews, and siblings are valued by the subjects as key relatives (see Table 20).

Table 50 presents a summary of the crosstabulation of surviving child and key relative. The association between surviving child and key relative has a Cramer's V value of 0.89683. The crosstabulation shows that subjects with children usually have their son or daughter

Table 50

Crosstabulation of Surviving Child and Key Relative

	Key Relative					
	Son	Daughter	Grand-Child	Sibling	Niece or Nephew	Significant Other
Surviving Child						
Yes	8 (16%)	17 (34%)	1 (2%)			2 (4%)
No				7 (14%)	8 (16%)	7 (14%)

as their key relative while those with no children have siblings, nieces, nephews and significant others as their key relatives. These results are consistent with the results of the crosstabulation of marital status and key relative (see Table 49) and reflect the value placed by subjects on their relationships with their relatives and significant others (see Table 20).

Summary

The results of the data analysis have been presented. Data included demographic and descriptive information about the subjects and their families; descriptive information about the social exchanges that occur between the subjects and their family members; and an analysis of associations between the demographic characteristics of the subjects and their families, and the social exchanges they participate in with each other.

CHAPTER FIVE

Summary, Findings, Conclusions Implications and Recommendations

Summary

The purpose of this study was to explore and describe the activities with family members that were valued by residents of a LTC Facility. Specific questions to be answered were: 1) Which activities with family members do residents value? and 2) Is there a relationship between demographic characteristics and valued activities?

Exchange theory provided a conceptual framework for studying the activities that occur between the elderly residents of a LTC Facility and their family members. A review of selected literature revealed that a modified family structure exists in North America in which social exchanges occur amongst family members resulting in the provision of mutual aid and support. When admission to a LTC Facility is necessary, the social exchanges of family members change from their focus on activities involving physical care to a focus on activities providing emotional and social support to elderly relatives.

Fifty residents from a LTC Facility in Vancouver volunteered for participation in this study. A modification of the Questionnaire for Resident/Patient (Dobrof, 1976) was administered to these residents.

Data from the questionnaires were quantified, coded and placed on a computer file. All data were analyzed using procedures in the SPSSx computer program. To answer research question one (Which activities with family members do residents value?) descriptive statistics with frequency distribution, measures of central tendency and dispersion were used to analyze the data. To answer research question two (Is there a relationship between demographic characteristics and valued activities?) correlations between demographic variables of families and residents, and activities identified as being of value to residents were established by crosstabulating the data and using Cramer's V and Phi calculations.

Findings

The data showed that the 50 subjects of this study are similar to residents of other LTC Facilities, but they differ in important characteristics from the 65 and over cohort in Vancouver. They are older; they are likely to have had serious health problems in the time period prior to their entry into the LTC Facility; they are more likely to have been single or widowed; and the female/male ratio is significantly higher in the LTC Facility than in the aged cohort in the community.

Data analysis showed that subjects participate in a variety of social exchanges with members of their modified extended families. The data showed that subjects identified visits and phone calls as the

activities with family members that they value the most and find the most supportive. The personal assistance activities most valued by subjects are having transportation to outside appointments and clinics, and having relatives take them shopping or shopping for them.

Data analysis revealed a number of significant associations between the demographic characteristics of the subjects and their relatives, and the valued activities. Significant associations were found between the demographic characteristics surviving child and visits by daughter, phone calls with daughter, exchange of cards with daughter, and being taken to a daughters home; visits by significant other; and between level of care and personal assistance activities with significant other. Crosstabulations showed that when subjects had daughters, the majority of the daughters participated in the valued activities visiting, phone calls, exchanging cards, and taking their parents to their homes. The crosstabulation of surviving child and visits by significant other showed that subjects who do not have a surviving child have a large number of visits from significant others, while those who have a surviving child have fewer visits with significant others than those subjects who do not have a surviving child. A significant association was found between level of care and personal assistance activities with significant others. When assessed at the Personal Care Level the majority of subjects did not receive help with personal care activities from significant others, but as their level of care increased to Intermediate I and II a greater

number of them participated in activities with significant others involving help with personal assistance activities.

Significant associations amongst the demographic data were noted. There was a significant association between marital status and key relative. Single subjects more frequently chose siblings, nieces, nephews and significant others as their key relative; while married and widowed subjects identified their sons or daughters as their key relative. A significant association was also found between surviving child and key relative which showed that the majority of subjects with surviving children chose them as their key relative whereas those with no surviving children chose siblings, nieces, nephews and significant others.

Also noted in the data analysis were the findings that some subjects value exchanging gifts with their families but others do not want, or receive gifts; subjects name daughters as their key relative twice as often as other relatives; that social exchanges with relatives have remained the same or increased since admission to the LTC Facility; and that less than half of the subjects report being asked by relatives about the type of activities they would like family members to have with them.

The generalizability of these findings is limited by a number of factors. The findings are based on the responses of a relatively small convenience sample of 50 subjects in one LTC Facility in Vancouver. It is possible that a larger and more diverse group of residents, who

are more representative of the three levels of care and from a variety of LTC Facilities, would respond differently regarding the types of social exchanges they value with their relatives. It is also possible that the subjects who volunteered for this study were a particularly cooperative and content group of residents, and may not be entirely representative of the total resident population.

Conclusions

The findings of this study suggest the following conclusions:

1) The subjects value participating in social exchanges with family members. The social exchanges most valued by subjects are visits, phone calls and personal assistance with transportation to appointments and clinics, and having assistance with shopping.

2) The findings that subjects who had a surviving child participated in significantly more activities with, and received more assistance from daughters than from other family members or significant others, make it possible to conclude that daughters play a valued role in the care and support of their elderly parents. The findings that subjects without a surviving child participated in more activities with and received more assistance from significant others, siblings, nieces and nephews, make it possible to conclude that significant others, siblings, and nieces and nephews are valued for the care and support they give to elderly relatives who do not have children.

3) The finding that as the subjects' level of care increased they received significantly more help with personal assistance activities from significant others, makes it possible to conclude that in spite of the fact that subjects are in a LTC Facility, as their conditions deteriorate they require increased support from their significant others.

Implications and Recommendations

The findings of this study have implications for nursing practice, education and research. Data from this study indicating the types of activities with relatives that elderly residents value and find supportive, gives direction to nurses to facilitate and encourage discussion between the elderly and their family members about the types of activities that they value with each other. Data indicating the significant correlation between increasing Level of Care and help with personal assistance activities from significant others gives direction to nurses to reinforce with family members the importance of their continued support to elderly relatives as their conditions deteriorate, and to make suggestions about helping them with various personal assistance activities. As well, information about the types of activities that residents value can be used by nurses in planning activities and care for residents of LTC Facilities.

Data from this study indicating the many social exchanges that daughters participate in as they care for and support their elderly

parents, gives direction to nurses working in the acute care and community settings to be alert to ways in which they can provide support and assistance to these daughters. It is this researcher's experience that when health care workers are supportive to and help to plan relief for busy daughters, they are often able to help daughters maintain their relatives in their homes longer, rather than having them admitted to an institution.

Demographic trends and data indicating that the subjects were in a variety of settings prior to admission to the LTC Facility suggests that nurses in all settings could benefit from education about the value of social exchanges between the elderly and their family members. As well, nurses need to develop skill in facilitating the identification of the wishes and needs of the elderly in regard to their social exchanges with family members. Nurses need to learn the importance of counselling family members to ask their elderly relatives their wishes regarding the activities that they participate in together. Inservice education programs and workshops for nurses could incorporate this type of information and offer relevant learning experiences to nurses.

Analysis of data in this study gives direction for further research. Data indicating that daughters are involved in many social exchanges with their elderly parents as they provide support and care to them; that subjects find having relatives available is very supportive; that a number of subjects do not wish to exchange gifts with their

relatives and that many residents were from a similar protestant background gives direction for the following studies:

1) A study to identify effective ways to provide support to daughters who are caregivers of elderly relatives.

2) A study to identify what residents of a LTC Facility mean by relatives "being available" and by what means relatives convey this availability.

3) A study to identify the views of residents of a LTC Facility about the exchange of gifts with family members.

4) A replication of this study with a larger number of subjects who are more representative of the total population of Canada.

This concludes the study of activities with family members that are valued by residents of a LTC Facility.

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Appendixes

Appendix A: Questionnaire for Resident/Patient

Questionnaire for Resident/Patient

Part I

No. _____ Level of Care _____

Date_____ Diagnosis(es) _____

Identifying Information:

1. Age _____
2. Sex
   1. Male
   2. Female
3. Date of admission to Institution
   1. mo_____ year_____
   2. unknown_____
4. Marital Status (at admission)
   1. Single
   2. Married
   3. Widowed
   4. Divorced
   5. Separated
   6. Unknown
5. Religion
   1. Protestant
   2. Catholic
   3. Jewish
   4. Unknown
   5. Other

Living Arrangements at Time of Application:

6. Residence
   1. Private Home
   2. Non-private household
   3. Institution or hospital
7. Location
   1. Vancouver
   2. Outside Vancouver

8. Living Arrangement
   1. Alone
   2. With someone

9. Household composition (or in same building)
   Check as many as apply:
   1. Alone
   2. Unmarried, widowed or divorced daughter(s)
   3. Unmarried, widowed or divorced son(s)
   4. Married daughter & family
   5. Married son & family
   6. Sibling(s)
   7. Spouse
   8. Other relative(s) Specify_____
   9. Friend
   10. Paid companion
   11. Unknown

10. If in institution or hospital at time of application for 6 months or less, what was prior place of residence?
    Where ? 1. Private home
    2. Nonprivate household
    With whom? _____
    (1 - 11)

11. Stated reason for admission to institution (2)
   1. Can't manage
   2. Loneliness
   3. Changing neighbourhood
   4. Loss of apartment or home
   5. Change in status of old person's family
      Specify-_____
   6. Death of spouse
   7. Financial need
   8. Poor health
   9. Fear of declining health status
   10. No surviving family
   11. Other

Family Composition:

12. Number of surviving children
    1. Sons _____
    2. Daughters _____
13. Ages of surviving children
    1. under 35 _____
    2. 35-65 _____
    3. 65+ _____
14. Do you have grandchildren?
    1. Yes
    2. No
15. Do you have great-grandchildren?
    1. Yes
    2. No
16. Do you have surviving siblings?
    1. Yes
    2. No
17. If yes, age:
    Female: 1. Under 65 _____
    2. 65-75 _____
    3. 75 + _____
    Male: 1. Under 65 _____
    2. 65-75 _____
    3. 75+ _____
18. Do you have nieces or nephews?
    1. Yes
    2. No

Family Availability:

19. Relatives proximity to institution:

	None Living	Within 1/2 hr.	Metro Vancouver but 1/2 hr. +	Outside Metro Vancouver
1. Son(s)				
2. Daughter(s)				
3. Grandchild(ren)				
4. Sibling(s)				
5. Nieces or nephews				
6. Other				

20. Who is defined as key relative?

A._____ B. None _____
(1,2,3,4,5,6)

Part II

21. Resident/Patient Mobility
    1. Unlimited
    2. Limited to institution
    3. Unit bound

22. Special handicaps:
    1. Deaf
    2. Blind or partial sighted
    3. Gait
    4. Memory problem
    5. Incontinence
    6. Other

Contacts and patterns of mutual aid between resident and family:

23. Do you have visitors?
    1. Yes
    2. No

24. If yes, who and how often?	2 x week	1 x week	2 x month	1 x month	less often
1. Daughter(s)					
2. Son(s)					
3. Spouse					
4. Daughter(s)-in-law					
5. Son(s)-in-law					
6. Sister(s)					
7. Brother(s)					
8. Granddaughter(s)					
9. Grandson(s)					
10. Other					

25. Would you like your relative(s) to visit more often?
    1. Yes
    2. No

26. If yes, who?

_____

1, 2, 3, 4, 5, 6, 7, 8, 9, and/or 10

27. Is there a reason why this is not possible?
    1. Too far
    2. Family or business responsibility
    3. Illness
    4. Illness in family
    5. Money
    6. Other
    7. No reason
    8. Unknown
    9. Institution regulations
    10. Lack of facilities for visitors

Activities which families sometimes do:

28. Contacts with family members: Who (1, 2, 3, 4, 5, 6)
    a) Visits to you _____
    b) Phone calls _____
    c) Letters _____
    d) Cards on special occasions _____
    e) Taking you to their home(s) _____
    f) Taking you for drives to restaurants _____
    g) Other _____

29. Which of the above activities with family members do you value most?

30. Are there activities that you would value more than those mentioned? Elaborate.

31. Would you like your relatives to have more contact with you?
    a) Yes
    b) No
32. In what way?

33. Do family members give you the following gifts?
    1. Food treats (specify)_____
    2. Small necessities (specify) _____
    3. Clothes
    4. Jewelry
    5. Books, newspapers,magazines
    6. Radio and/or T.V.
    7. Refrigerator
    8. Furnishing (chair, pictures, plants)
    9. Spending money
    10. Telephone bill
    11. Facility fees
    12. Other

34. What is it about gifts from family members that is of particular value to you?

35. Personal Assistance Activities with family: Who (1, 2, 3, 4, 5, 6)
    1. Transportation to outside doctors, clinics
    2. Shopping with or for you
    3. Conferences with staff
    4. Sewing
    5. Errands and repair (shoes, glasses,cleaning)
    6. Reading to you
    7. Taking you to activities and appointments within the institution
    8. Feeding
    9. Personal care
    10. Other

36. Are any of these personal assistance activities with family particularly valuable to you?

37. Does your family come to special family programs at the institution?
    1. Yes
    2. No
    3. No programs

38. Since you have been in the Institution, have your contacts with your family
    1. Decreased
    2. Increased
    3. No change
    4. Don't know

39. Has your family asked you what type of activities you would like them to do with you?
    1. Yes
    2. No

40. If your family asked you to name the activities that would provide you with the most support and contact, what would you reply?

41. Does the Facility do everything it can to help you and your family maintain contact?

    1. Yes
    2. No

42. What more could the Facility do?

Appendix B: Letter of Permission to Use Questionnaire for Resident/Patient and Dated Envelope

Appendix C: Letter of Permission from
Manager of LTC Facility

Appendix D: Information Letter for Residents

Appendix E: Consent Form