THE CHALLENGE OF COPING: FRAIL RURAL ELDERLY COUPLES IDENTIFY RESOURCES REQUIRED TO MAINTAIN THEIR INDEPENDENCE

By

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THE CHALLENGE OF COPING:

FRAIL RURAL ELDERLY COUPLES IDENTIFY RESOURCES REQUIRED TO MAINTAIN THEIR INDEPENDENCE

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ABSTRACT

Frail elderly couples, residing in their own homes, in rural communities of 1,500 to 2,500 people, in south western Manitoba, were asked about the resources that they perceived as necessary to maintain their living arrangements. The qualitative approach utilized a purposive sample of 19 frail elderly couples, known to Continuing Care and Support Services to Seniors programs in selected communities, to inform in detail about personal meaning and experience. Elderly couples were asked to identify, describe and evaluate the health care resources, other types of resources or services and supportive persons that assisted them in their efforts to remain living independently in the community. The roles and relationships of the spouses, in functioning and adapting to their living situations as couples, were also examined. The study resulted in a list of resources and a model to describe the factors which contributed to the independence of these frail rural elderly couples. A synergism or energy generated by mutually supportive dyads, functioning as single couple units, was identified as an important resource to elderly couples, and a continuum of spousal relationships of frail elderly couples was generated. The study contributes to the understanding of resources and supportive services beneficial to frail rural elderly couples, and provides information to the field, as well as to planners, service providers, communities, businesses, families and elderly couples themselves.

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CHAPTER 1 — INTRODUCTION

An increasing number of frail elderly couples are seeking resources to support their efforts to remain living together, independently, in the community (Che-Alford, 1994; Connidis, 1989; Norland, 1994; Stone, 1988). While the public and private health care sectors have been developing services to meet the growing requirements of the senior population (Clark, 1992; Havens, 1990, 1995; Neysmith, 1993; Oktay, 1988; Ozawa & Morrow-Howell, 1992; Stoller & Cutler, 1993), the special issues and needs of frail elderly couples have not been adequately addressed (Getzel, 1982; Gladstone, 1995; Gregory, Peters & Cameron, 1990; Lichtenberg & Barth, 1989; Mittelman et al., 1993; Staight & Harvey, 1990). A common pattern occurs, with the healthier spouse caring for a precarious partner, for as long as possible, at which time the frailer partner is institutionalized (Cohen et al., 1993; Coward, Duncan & Freudenberger, 1994; Mittelman et al., 1993). A couple, who have been together for 50 or 60 years, may thus be forced to spend their remaining years apart, regardless of their personal preferences.

Issues of availability, accessibility and appropriateness of services, for seniors residing in rural communities, have been receiving increasing attention from researchers and service providers (Canadian Morgage and Housing, 1991; Coward & Cutler, 1989; Everitt & Gfellner, 1995; Grant & Rice, 1983; Joseph & Fuller, 1988; Keating, 1991; Salmon, Nelson & Rous, 1993). These issues, as they relate to frail elderly couples, have been examined to a much more limited degree (Dorfman & Heckert, 1988).

Also of importance is understanding the supportive relationships, experienced by seniors, with particular attention to the impact of these relationships on the ability of

elderly couples to remain independent (Cantor, 1992; Connidis, 1989; Stone 1988). Relationships between spouses, as their interactions contribute to their ability to function and remain independent, also warrants examination (Ade-Ridder & Brubaker, 1983; Anderson & McCulloch, 1993; Tower & Kasl, 1996).

The purpose of this project was to determine what resources were identified as supportive by frail elderly couples living in rural communities; to explore how the health care sector and other sectors delivered services to meet their needs; and to identify additional supports which could be further developed to assist these couples in their efforts to continuing to live together, independently in the community. The experts, with the greatest potential to answer these questions, are rural elderly couples themselves (Gubrium, 1992). As well, narrative is recognized as a process of continuous accounting whereby the incidents and events of daily life are given order and meaning (Williams, 1984). Qualitative study is defined by Creswell (1994) as "an enquiry process of understanding a social or human problem based upon building a complex, holistic picture, formed with words reporting in detail views of informants and conducted in a natural setting". Therefore, the study used a qualitative approach to focus on the interaction and narrative of frail elderly couples residing in rural communities, through a semi-structured interview process which allowed participants to elaborate and move the discussion in directions of importance to them..

RESEARCH QUESTIONS

Primary Research Question

In rural communities, what resources do frail elderly couples perceive as necessary to remain living together, independently, in their own homes?

Sub-questions

Several sub-questions were developed including: What resources do frail elderly couples identify as being available in the health care sector? In other sectors? What precipitating factors do elderly couples perceive as determining their need for resources? How do they describe and evaluate the availability and adequacy of existing resources? What barriers and facilitators do they identify as having an impact on access to resources? What resources do they identify as needed, but unavailable? What issues, related to their health and health care, are of concern to them?

CHAPTER 2 — LITERATURE REVIEW

CHANGING DEMOGRAPHICS

The 1991 Census of Canada reported that 3.2 million or 11.6% of Canada's population was 65 years of age or older. The proportion of seniors is anticipated to exceed 8 million (20% of the population) by 2031 (Norland, 1994). In 1991, the census showed the growth in the proportion of younger seniors (65 - 74 years) to be the lowest compared to growth in the proportions of intermediate seniors (75 - 84 years) and older seniors (85+ years). This trend is expected to continue over the next two decades, with the projected proportion of seniors, 85 years and older, increasing from 9% in 1991 to 14% in 2011 (Moore, Rosenberg & Bekkering, 1989; Norland, 1994).

Of the 3.2 million elderly people in Canada, aged 65 years and older, the majority (83.5%), lived in the household they maintained; and 51.3% resided with their spouse (Che-Alford, 1994; Norland, 1994). An increase is shown from 1971, when approximately 800,000 seniors aged 65 years and older, lived in the household they maintained with their spouse, to 1991 with over 1,600,000 seniors doing so. In 1991, 35% of those 75 years and over, lived with a spouse in their own household (Table 1).

The proportion of elderly persons varies among the Canadian provinces, with Manitoba reporting among the highest figures. In 1981, 11.5% of the population of Manitoba was 65 years of age and over. By 1991 that figure increased to 13% and by 1995 it was 13.4% (Manitoba Health, 1981, 1986, 1991, 1995). Some rural areas of Manitoba have even higher proportions of seniors, with Westman Region (Figure 1) having 17.8% of its total population being 65 years and older (Table 2).

Table 1 Canadians, Aged 65 & Older, Living With Spouse, In Own Household 1991, 1981, 1971

	Total 65 years & over	%	65 to 74 years	%	75 and over	%
Total 1991	3,157,625	100.0	1,887,110	100.0	1,270,515	100.0
Maintain own household	2,636,580	83.5	1,708,225	90.5	928,350	73.1
Live with spouse	1,621,230	51.3	1,176,030	62.3	445,200	35.0
Male	925,840	29.3	643,610	34.1	282,225	22.2
Female	695,390	22.0	532,515	28.2	162,980	12.8
Total 1981	2,347,945	100.0	1,469,165	100.0	878,785	100.0
Maintain own household	1,884,735	80.3	1,289,755	87.8	594,980	67.7
Live with spouse	1,163,585	49.6	880,895	60.0	282,690	32.2
Male	688,420	29.3	502,475	34.2	185,940	21.2
Female	475,170	20.2	378,415	25.8	96,760	11.0
Total 1971	1,744,405	100.0	1,077,340	100.0	667,065	100.0
Maintain own household	1,306,050	74.9	881,230	81.8	424,820	63.7
Live with spouse	814,040	46.7	604,000	56.1	210,040	31.5
Male	493,540	28.3	352,905	32.8	140,635	21.1
Female	320,500	18.4	251,095	23.3	69,405	10.4

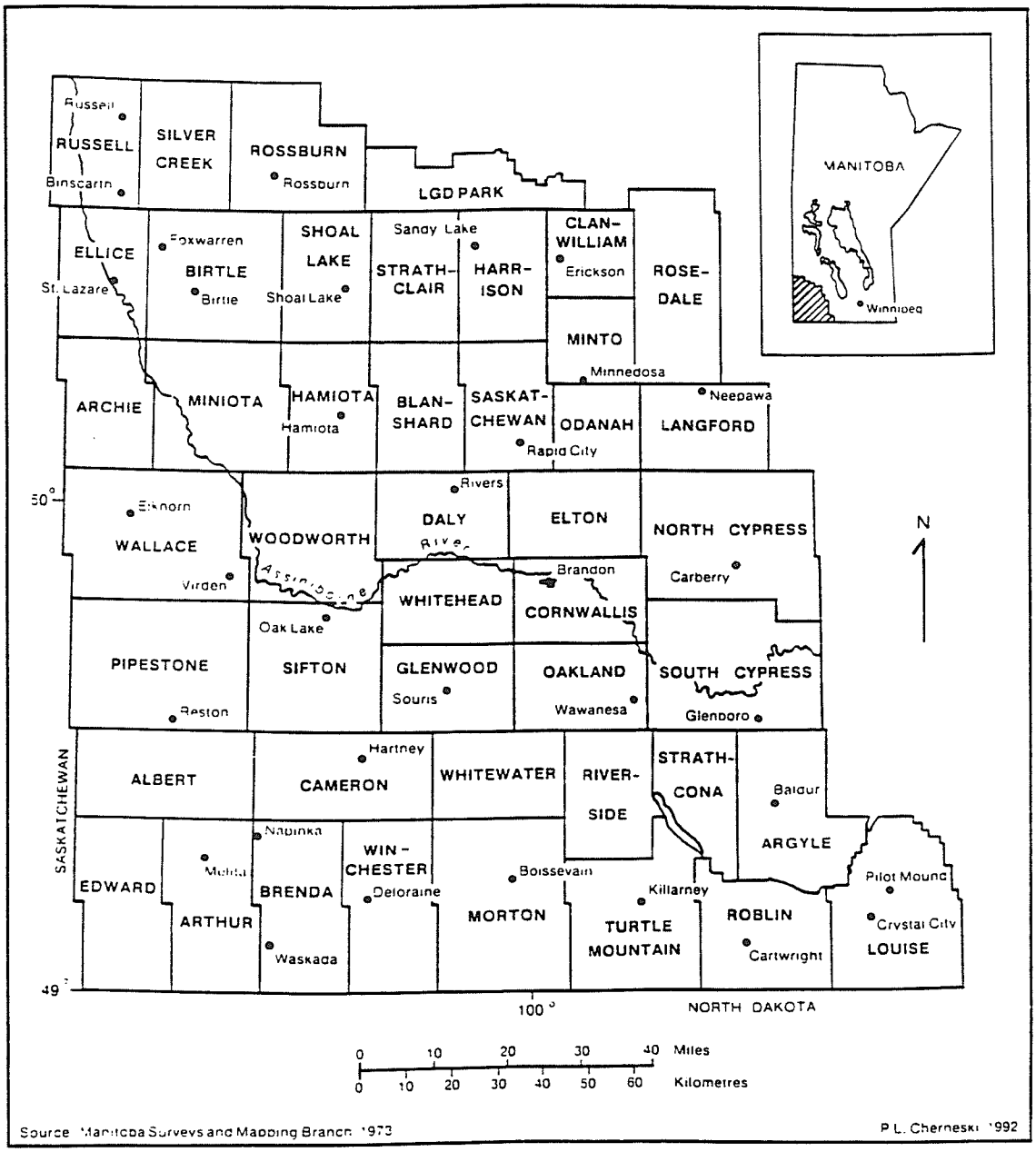
Source: Che-Alford, J. (1994). Families in Canada. Statistics Canada Catalogue No. 96-307E. Scarborough, ON: Prentice Hall.

Table 2 Westman Population, Aged 65+, By 5 Year Age Groups

Age	1981	1986	1991	1995
65 - 69	5755	5752	5630	5463
70 - 74	4803	5057	5122	5248
75 - 79	3473	3892	4169	4216
80 - 84	2245	2544	2924	3165
85 - 89	1304	1386	1612	1769
90+	684	792	907	985
Total 65+ (% of Total)	18,264 (15.2%)	19,423 (16.1%)	20,293 (17.5%)	20,846 (17.8%)
Westman All Ages	120,019	120,299	116,074	116,936

Source: Manitoba Health Population Reports - December, 1981, 1986, 1991, June 1995

Figure 1 Map of Westman



Source: WESTARC. (1994). Westman Rural Health Improvement Project. Brandon, MB: Author.

In addition, the numbers of younger seniors aged 65 to 69 is decreasing, while those in the older age categories are increasing and will continue to increase over time.

Many rural communities in Westman report that over 25% of their population is 65 years and older, and over 12% is 75 years and older. The proportions of seniors in Westman communities, with between 1000 and 4000 people, are shown in Table 3.

Table 3 Westman Communities with Populations of 1000 - 4000 Residents

Community	Total Pop.	Percent 65+	Pop. 65+	Percent 75+	Pop. 75+
Neepawa	3,636	26.79	974	15.73	572
Minnedosa	3,081	23.95	738	12.33	380
Virden	3,154	25.27	797	14.27	450
Killarney	2,311	27.74	641	13.54	313
Russell	1,826	23.55	430	12.10	221
Souris	1,673	31.38	525	17.63	295
Carberry	1,649	21.10	348	12.80	211
Boissevain	1,604	24.00	385	14.21	228
Melita	1,390	24.60	342	14.24	198
Rivers	1,184	25.08	297	12.75	151
Deloraine	1,098	36.70	403	20.31	223

Source: Manitoba Health Preliminary Population Report - June 1995.

As the number of elderly persons continues to escalate, so do the number of frail elderly persons (Dunn, 1990) and of elderly couples (Che-Alford, 1994; Connidis, 1989). With seniors living longer, the number of couples reaching frail older ages is increasing. As well, more seniors are marrying and re-marrying later in life (Norland, 1994). The result is an expanding number of frail elderly couples, striving to remain independent in their own homes. Anderson and McCulloch (1993), suggest that the

relationships experienced by spouses, as they provide care to failing partners, represents perhaps the most unique and intimately supportive of all human relationships.

SPOUSAL CAREGIVING

According to Shapiro (1993) "about 80% of the help needed by the elderly is provided by informal resources such as family members, neighbours, and friends". Cantor (1991) states that in most cases the informal caregiver will be the spouse, if one is available and capable. Her research shows that a spouse is a member of a singularly important group, which often carries a substantial portion of the support function, suffers more from strain and about which we know relatively little. Stoller (1992) calls spouses the first line of defence for elderly people coping with disease or disability. She believes that spouses handle a broader range of tasks, provide more hours of assistance and are more likely to provide personal care than are other caregivers.

Substantial research has been conducted to explore informal and family caregiver burden. Aneshensel, Pearlin & Schuler (1993) studied role captivity, the involuntary absorption of a person into a caregiving role; Stull, Kosloski & Kercher (1994) examined caregiver burden and its influence on the well being of care providers; and Logan & Spitze (1994), Miller & McFall (1991) and Tennstedt, Crawford & McKinlay (1993) investigated caregiver burden and informal supports as they related to the use of formal services. While the literature addressing informal caregiving identifies the spouse as the most frequent primary caregiver (Cantor, 1990; Chappell & Penning, 1990), and some literature focuses on spousal caregivers (Allen, 1994; Hooker, Frazier & Monahan, 1994; Lichtenberg & Barth 1989), little attention has been placed on the

spousal relationship and the distinctive needs of the frail elderly couple, as partners strive to remain together.

Allen (1994) and Millar (1990) explored gender differences in spousal caregiving; Hooker, Frazier & Monahan (1994) looked at personality and coping of spousal caregivers; Lichtenberg & Barth (1989) studied the mental health of spousal caregivers as it relates to the stage of caregiving they provide; and Mittelman et al. (1993) evaluated an intervention to assist spousal caregivers of those with Alzheimer's Disease. Gregory, Peters & Cameron (1990) reviewed the literature on male spouses as caregivers and Harris (1993) examined male caregivers of Alzheimer's Disease victims. These studies looked at the spousal caregiver, and minimal consideration is given to the relationship of the couple as a unit.

However, Anderson & McCulloch (1993) examined the factor structure of social supports among 298 older marital dyads by interviewing both spouses simultaneously using two separate interviewers. Wright (1991) explored the impact of Alzheimer's Disease on the marital relationship by studying two groups of couples, one with a partner having been diagnosed with Alzheimer's Disease and the other with no such diagnoses. Here semi-structured interview questionnaires were used and within couple and between couple comparisons were made. In both of these studies, each partner was interviewed and answered separately from the other partner, couples were not interviewed as a single unit. Kenny & Kashy (1991) suggest that "People in dyadic social interaction co-ordinate their thoughts, feelings and behaviours. At the extreme, this co-ordination represents a merging of two people into one. The two people

transcend their own identities and become something together that never was before" (p.275). They conclude that interdependence should be viewed as a primary construct for the study of dyads.

FORMAL SUPPORTS AND SERVICES

Health care services, such as respite programs, adult day care, home support and home nursing, are being developed and delivered in the community, in an effort to prevent or delay institutionalization of elderly persons. Adult day programs as respite services were explored by Henry & Capitman (1995); Logan & Spitze (1994) studied seniors use of seniors' centres and home-based services ; Ozawa & Morrow-Howell, 1992 looked at a neighbourhood network to access seniors' services; Shapiro (1986) explored the patterns and predictors of Home Care use by the elderly; and Chappell & Blandford (1991) studied the relationship between the use of informal and formal care.

Adaptation of formal programs, to specifically meet the needs of elderly couples, is limited, and sparsely mentioned in the literature (Barusch, 1988). Straw, O'Bryant and Meddaugh (1991) suggest that spousal caregivers are a special group, who view caregiving responsibilities as very personal or as part of the marital contract. Therefore, they are less eager to seek or accept assistance. It becomes apparent that there is a need to better understand the couple as a unit and its need and use of formal supportive services.

RURAL COUPLES

Meeting the needs of frail elderly couples poses a unique challenge. This challenge is further compounded when elderly couples choose to spend their remaining

years residing in a small rural community (Canada Mortgage & Housing, 1991; Corin, 1986; Coward & Cutler, 1989; Everitt & Gfellner, 1994, 1996; Joseph & Cloutier, 1990). Issues of transportation, housing and availability of supportive services predominate. According to Martin-Matthews (1988), rural environments pose a set of circumstances which are socially, psychologically, economically and geographically unique and important.

In rural communities, as well as urban centres, seniors require and use resources and supports from informal and formal sources (Clark, 1992; Corin, 1986; Krout, 1989). Formal supports may be provided by the health care sector, as well as other sectors of the community. At a time when competition for government health care dollars is increasing and availability of these financial resources is decreasing, the opportunity and need for commercial health services and other private sector businesses to serve the needs of seniors, is growing. The decrease in federal transfer payments to the provinces to support health care delivery, coupled with the move to regionalization of health care services and programs, provides an environment of uncertainty and social change. Rural community planners are trying to identify how local businesses can deliver services in a manner, which addresses the needs of the elderly population as consumers (Kaiser & Camp, 1993); and to determine the services that should to be developed to meet their need for support (WESTARC, 1991; Coward & Cutler, 1989). Some rural areas are courting elderly retirees as migrants to their communities (Rowles & Watkins, 1991). A move to adapt services to meet the needs and preferences of seniors applies to government and private sector business, in health care and other service sectors.

The need for research to assist in planning services for the growing numbers of elderly couples, and more specifically for those living in rural communities, is evident (Keating, 1991). The goal of this project was to address that need by exploring the world of frail rural elderly couples, to identify the resources that these seniors perceive as being necessary to remain living together independently in their own homes.

In examining the supportive resources of elderly couples, it is also important to determine what types of individuals, friends, family and others are stabilizing forces in their worlds. As well, it is useful to understand how each spouse contributes to the dyad or couple and how the ability of the couple to function and adapt as a unit contributes to the success of the couple in remaining independent in the community. Elderly individuals experience a substantial prevalence of chronic illness, in addition to physical decline related to the normal aging process (Huyck & Hoyer, 1982). Williams (1987) suggests that the function of the family, in this case the couple, effects the course of adaptation to disability for each member of the family and for the whole family unit. Williams (1987) further postulates that a reciprocal exchange of activities within a family is a rational and appropriate response to difficulties, but the values people attach to tasks and to social roles will also have an impact. Kaufert (1983) notes that role expectations and the division of labour within a household may also influence the functional performances of males and females. Given the importance of the spousal relationship, the adaptation of the couple to their current living situation and their ability to cope as a unit, will also be explored.

CHAPTER 3 — METHODOLOGY

The methodology section details the operational definitions; the research design; sample selection; data collection and data analysis techniques as well as ethical considerations.

OPERATIONAL DEFINITIONS

Definitions of 'frail elderly couple', 'rural', 'living independently', 'own home', 'supportive resource' and 'caregiving' have been operationalized according to the intended use of these concepts throughout the study.

Frail Elderly Couple

The most difficult term to clarify is 'frail'. Tennstedt and McKinlay (1994) define 'frail' as referring to chronically dependent older people with a variety of physical and/or cognitive impairments that impede daily functioning. Shapiro (1993) suggests the descriptor 'vulnerable' refers best to elderly persons that are disabled or chronically ill, with little or no access to informal resources. She provides categories, suggesting that the vulnerable elderly population falls into three groups—1.) those who need to be placed in a long-term care facility because they can no longer remain at home; 2.) those who require community care because they can no longer manage completely on their own at home; and 3.) those whose caregivers need assistance to reduce the cumulative stress and fatigue associated with maintaining another elderly individual at home.

Rockwood, Fox, Stolee, Robertson & Beattie (1994) advise that 'frailty' is best

defined using a dynamic model, which encompasses both the biomedical and psychosocial aspects of the term. Brocklehurst (1985) developed a "model of breakdown" which included factors that affect whether a person can live in the community. On one side of the balance are assets for maintaining independence, such as -- health, functional capacity, a positive attitude toward health and other resources (social, spiritual, financial and environmental). On the other side are deficits, which threaten independence -- ill health (particularly chronic disease), disability, dependence on others for activities of daily living and burden on caregivers. Brocklehurst recognizes that for those dependent on others, the caregiver is a crucial asset and the burden on the caregiver is an equally important deficit. This model applies particularly well to spousal caregiving.

For the purpose of this study, a 'frail elderly couple' was defined as a partnership, with both partners being 75 years of age or older, and one or both experiencing physical or cognitive deterioration, placing the couple at risk of being unable to care for themselves and continue to live independently. The degree of 'frailty' may fluctuate over time for each couple, or for either member of the couple.

Rural

Martin-Matthews (1988) describes several difficulties that exist in the effort to define 'rural'. Sometimes individuals are seen as 'rural' if they reside on a farm, in a small town or village with a population of less than 10,000 people (Canada Mortgage & Housing, 1991; Hodge, 1987). Statistics Canada defines the rural population as that remaining in an area after the urban population is defined, with the urban threshold

being 1,000 people. Joseph and Martin-Matthews (1993) include small towns of 1,000-4,999 as integral elements of the rural settlement system. Joseph & Cloutier (1990) include towns of 1226 and 4380 residents in their work with rural communities in Ontario. In Saskatchewan cities are defined as communities with 5,000 or more inhabitants (Li & MacLean, 1989). Grant & Rice (1983), also working in Saskatchewan, considered rural communities as those with 5,000 residents or less.

Everitt (1994) focuses on Manitoba and speaks of small rural communities between 2,500 and 4,999 people. The Municipal Act of Manitoba (1988) states that to become incorporated, a town must have a population of more than 1,500 inhabitants. Revisions to the Act are currently under discussion and the proposed legislation is vague, requiring an area with at least 1,000 residents and a population density of at least 400 residents per square kilometre for the formation of an urban municipality (R. Grodzik, personal communication, November 8, 1996). No single definition of rural or urban has emerged over time or across areas.

For the purpose of this study rural was defined as including communities with populations of less than 5,000 people. The Westman Region was selected for this study because of its substantial proportion of seniors, with 17.8% of the population aged 65 years and older. The majority of communities in Westman have less than 1,000 residents, with no communities in the 4,000 range and only three in the 3,000 range (WESTARC, 1994). See Table 3, page 7. Smaller communities are dwindling, and seniors appear to be retiring to the larger communities with populations above 1,000 and at least a minimal selection of services.

Living Independently

Perhaps the most comprehensive understanding of 'independence' is demonstrated by Keating (1991). She describes independence as composed of three criteria – 1.) the ability to maintain control over the near environment, meet basic personal needs and maintain responsibility for decisions in these areas; 2.) being part of the community, maintaining a separate household, not living in an institution and not being home bound; and 3.) having ease of access to basic services such as groceries, pharmacies, health care and banking. Stoller & Cutler (1993) indicate that 'living independently' does not suggest living without use of assistance and supports, but rather that the choice of resources is at the independent discretion of the user. The term 'independent living' as defined by the disability and rehabilitation literature suggests that individuals with disabilities are capable of taking charge of their own lives and making useful contributions to society. The essence of the message is that decision-making and control over one's life are the key to 'independent living', not the physical act of completing particular tasks (DeJong, 1979; Bartels, 1985).

For this study, seniors were considered to be 'living independently' if both members of the dyad were residing together outside of an institutional setting and were recognized as making choices as to what resources they prefer to access and use.

Own Home

Any non-institutional residence was considered one's 'own home', whether a rented or owned home, a single family dwelling or multiple unit housing (duplexes, row houses, condominiums, mobile homes, apartments and elderly persons housing units).

Supportive Resource

Keating (1991) defines basic services for elderly persons as including access to groceries, pharmacies, health care and banking. Coward, Duncan & Freudenberger (1994) suggest formal services include home health aides, home-maker services, physical therapy, transportation services and meal preparation. Shapiro (1993) identifies resource needs of vulnerable elders as involving sensitive physicians, a community care program, a geriatric assessment/rehabilitation unit, adult day care and respite care. Logan and Spitz (1994) classify spouses, children, relatives, neighbours and friends as informal supports. Seniors centres, meal services, and transportation services are seen as more formal supports.

In the current study, any program, service, business, organization or relationship, that was identified by the couple as supportive and providing necessary assistance for them to live independently, was considered a resource. Both informal and formal resources were included. Examples include the taxi service, grocery delivery, the church, the senior's resource co-ordinator, the family physician, the handivan, congregate meals and the grandson, who acted as chauffeur.

Caregiving

Allen (1994) suggests that a range of household management and nursing skills are required to assume a caregiving role. Her study looked at caregiving as related to instrumental activities of daily living (IADLs) such as house cleaning, cooking and shopping, as well as activities of daily living (ADLs) including bathing, dressing, getting in or out of bed. Cantor (1991) defines caregiving as a subset of social care

performed by either informal or formal providers. Social care is described as addressing three kinds of needs – 1.) opportunities for socialization, self-affirmation and self-actualization; 2.) assistance with everyday tasks of daily living; and 3.) personal care needs arising out of severe disability.

For this study, caregiving was defined as providing a variety of supports to one's spouse by undertaking household tasks or IADLs as well as providing assistance with personal care or ADLs.

RESEARCH DESIGN

Gubrium (1992) suggests that qualitative research has come of age in gerontology. He states that qualitative research is a way of knowing, a way of documenting the aging experience and making a contribution to the field. Qualitative research assists us to "understand what it means to grow or be older, how that varies in time and place, and what is particular and general about the process" (p. 582). Qualitative methods are best suited for the study of process and meaning (Rubinstein, 1994). To accurately identify the challenges that face frail elderly couples, and understand the attributes of resources that they recognize as effective, informant-centred qualitative research is ideal.

SAMPLE SELECTION

The intention of this study was to identify frail elderly couples, residing in their own homes in rural communities, conduct interviews with them and analyze the data to answer the research questions. It was anticipated that a framework and a list of services and supports might be developed as a result of the data collection and analysis.

Rural communities of 1,500 to 2,500 population, located in the Westman Region of Manitoba were used for the study, including Boissevain, Carberry, Killarney, Russell, and Souris (Figure 1, page 6 and Table 3, page 7). Distance of these communities from Brandon, the regional referral centre, and from Winnipeg, which provides more highly specialized health care services, are noted in Table 4.

Table 4 Distances between Selected Communities and Larger Centres

Rural Community	Distance from Brandon	Distance from Winnipeg
Boissevain	74 kilometres	241 kilometres
Carberry	51 kilometres	158 kilometres
Killarney	101 kilometres	217 kilometres
Russell	176 kilometres	338 kilometres
Souris	47 kilometres	226 kilometres

Source: Manitoba Highways and Transportation. (1994) *Manitoba 1994-1995 Official Explorer's Highway Map.* Manitoba: Author.

Each of these communities had a community program of Support Services to Seniors (Manitoba Health, 1992; WESTARC, 1991) and an extensive Continuing Care Program, which provided assessment, Home Care, adult day care and respite services (Havens 1994, 1995).

Co-ordinators for each of these programs were asked to identify elderly couples, with both spouses being 75 years of age or over, living in the selected communities or on a farm near the community. The assessment of the co-ordinators as to the frailty of the couples was seen as appropriate for screening as the co-ordinators are the local providers of services to seniors. Co-ordinators were asked to review their client lists

and identify elderly couples, who appeared to be experiencing challenges as they were striving to remain living together, in the community. The co-ordinators then asked the selected elderly couple clients, for permission to provide their names and phone numbers to the researcher. A letter of introduction to the project and the researcher were given, by the co-ordinator, to each couple who was invited to participate (Appendix 1). The names and phone numbers of couples who indicated a willingness to be interviewed, were provided to the researcher, by the co-ordinator. Most couples fulfilled their agreement to participate, however, on occasion, extremely poor health or death of a spouse caused a couple to withdraw from the study prior to the interview.

Each couple was informed about the project, and a consent form requiring the signatures of both partners was completed prior to the interview (Appendix 2). In cases where the caregiver spouse acted as a proxy for responses, that caregiver was asked to countersign the signature or sign of the impaired spouse. A semi-structured interview using a pre-set series of questions, allowing for expanded responses and exploration, was used to encourage frail elderly couples to talk about the challenges to their living situations. They were asked to identify resources and supports from their own experience. Their interpretation of what was a support, their description of it and their evaluation of its ability to meet their needs was documented. Suggestions for the improvement of services or development of new services was also recorded. The interview guide is found in Appendix 3.

The topics used to construct these questions were developed from a pilot interview, using an unstructured format with a frail elderly couple, as well as from the

literature review. Revisions were made to the interview guide as necessary during the data collection process, with a goal of consistency but with flexibility to allow the recording of any additional information put forward by the couples being interviewed.

The approach used was qualitative, which differs in many ways from the more familiar survey or experimental sampling techniques. Qualitative research relies upon a smaller number of informants, chosen to provide details about personal meaning and experience. Adequate sample size depends upon the unfolding of conceptual consistency in the data and on thematic pattern saturation (Rubinstein, 1994). Inquiry stops when patterns become repetitive and materials are thematically saturated.

Purposive or judgmental sampling was used to determine the sample selection. This methodology is appropriate when the intention is to study a small subset of a larger population, in which many members of the subset are easily identified, but the enumeration of all would be nearly impossible (Babbie, 1973). As a non-probability sampling methodology, its greatest weakness, the sample not being randomly selected, is also its greatest strength with the sample focusing on a select group of participants. However, it must be remembered that the intense detail derived from in-depth interviews of a selected few, is not generalizable to the population from which the sample was chosen. Initial cells were determined and adjusted only slightly as required during the study (Bernard, 1994).

It is important to note that the intent of the study was not to compare male and female caregivers, but to ensure that understanding and knowledge was gleaned from differing types of situations. It was initially anticipated that 18 couples would provide

sufficient detail of meaning. However, the adequacy of the sample would be determined by the consistency of the data gathered and thematic saturation. The sample selection by caregiver roles of couples is shown in Figure 2.

Figure 2 Sample Selection, by Caregiving Role

Cell	Sample
◆ female caregiver • physically impaired spouse • cognitively impaired spouse • combined physical and cognitive challenges of spouse	6 couples
◆ male caregiver • physically impaired spouse • cognitively impaired spouse • combined physical and cognitive challenges of spouse	6 couples
◆ shared support • a combination of physical and cognitive challenges noted with each partner assuming supportive activities	7 couples
Total	19 couples

Continuing Care (Home Care) Co-ordinators and Support Services to Seniors Co-ordinators were asked initially to suggest five couples per community. These couples were assigned to cells according to their caregiving situations. Some cells were

under filled, and additional requests were made of the co-ordinators. The intention was that the cells would be filled to a total of 18 couples, and the process would be re-instituted if additional couples were required because repetition and thematic saturation had not occurred. Two additional couples were interviewed, leading to a total of 20 interviews being conducted. One couple was added to the shared support category, and the other couple proved to be chronologically too young for the project (male aged 70 years, female aged 65 years).

Data Collection

The data were collected through a semi-structured interview process (Appendix 3). Each couple was interviewed and initially answered together. This was followed by an additional set of questions to be asked separately of each partner. The exception was in situations where an individual was cognitively impaired to a degree that he or she could not participate independently. In this situation, the caregiving spouse was considered either as an assistant or a proxy for the cognitively impaired spouse. Interviews were taped using a miniature tape recorder, and responses were also recorded on paper by the interviewer. Interviews were transcribed and cases were masked to maintain the anonymity of the couples who participated. During the interviews, some adjustments were made to the semi structured outline to include information on pastimes, number of children and use of technology. Whenever useful, attempts were made to clarify, and explore responses. This information was documented and some adjustment was made to provide for additional exploration in the interviews which followed. Becker (1993) states "Sensitivity to the emerging theory is severely restricted

if the researcher does not involve analysis throughout so that it can guide the process of data collection" (p. 258).

Field notes were used to describe interaction patterns reflecting the apparent relationship of the couple, as well as their communication with each other and with the interviewer. The context of the interview and observations, of the environment and the situation, made during the meeting were documented for each interview. It was recognized that responses made by each partner would be affected by the presence and influence of the other partner as detailed by Kenny (1996) in his description of models of non-independence in dyadic research. Efforts were made to note the obvious partner effects, mutual influence and common living factors as seen in both the behaviours and dialogues of the couples. This information was also useful in understanding the adaptation of the couple to their current living situation.

DATA ANALYSIS

Data analysis focused on the identification of common themes which emerged from the data on resources. The categories of resources were changed and refined as understanding grew and the research process continued. It was envisioned that a conceptual framework and a list of services and supports could be developed as a result of the data collection and analysis.

Data analysis was done in a detailed, labour-intensive manner, by the researcher. In response to the data collected and the status of the project, additional or altered questions were incorporated into the interview process. This response to the data enhanced the quality and comprehensiveness of the information still to be collected.

The result was a deeper, more complex understanding of the resources identified, used and needed by frail rural elderly couples. Analysis includes a discussion of individual and of dyadic responses, recognizing that there is a shaping of couple responses related to partner effects, and mutual influence of the spouses. The observation of the dyads and the adaptations of the couple and the partners within the couple unit were also analysed to identify what factors in couples relationships appeared to have an impact on the ability of the couple unit to continue to function independently in the community.

ETHICAL CONSIDERATIONS

It was important to maintain anonymity of potential informant couples, as well as of those couples who chose to participate. To ensure the anonymity of these elderly couples, the Continuing Care Co-ordinators and the Support Services for Seniors Co-ordinators provided an introductory letter to each couple they identified, describing the study, and providing them the opportunity to consider whether they wished to participate in the project (Appendix 1). Only after a couple indicated a willingness to consider participating, was their name and phone number provided to the researcher.

Those couples were contacted by telephone by the researcher and informed of the interview process. An interview was scheduled and prior to the interview, they were asked to sign a consent form (Appendix 2) detailing efforts to ensure their continued anonymity; to maintain confidentiality of the primary data; and stating their voluntary participation and right to withdraw from the interview at any time. Two copies of the consent form were signed by each spouse and the researcher. One copy was kept by the researcher and the other was left with the couple. Enhanced type consent forms and the

consent form on tape were available, in the event that any of the participants had substantial visual impairments. It was anticipated that those with hearing loss would be able to use the regular or enhanced type paper consent forms.

The locations of the communities involved in the study in Westman were noted, but no connection of any couple to any of these communities has been made. Primary data have been available only to the researcher and the thesis committee. These data will be destroyed following use by the researcher.

Where a spouse was cognitively impaired, the caregiving spouse was the primary informant. It was recognized that a proxy response does not provide the most complete data. However, given the inability of some individuals to respond for themselves, a proxy response was determined to be the best information that was available. Given the responsibility that the caregiving spouse assumes for a cognitively impaired individual in all other realms, it seemed most appropriate that the caregiving spouse be the proxy. Note was made of proxy responses and caution used in any conclusions drawn from such input.

Throughout the thesis documentation of the research and all subsequent publications, pseudonyms of individuals and places have been and will continue to be used to maintain the anonymity of the couples who were interviewed. The single case study contains fragments of detail from other cases in order to maintain the anonymity of the couple depicted.

CHAPTER 4 — FINDINGS

Findings recorded and analysed encompass 1.) characteristics of the couples, their ages, years married, residences, health and caregiving roles; 2.) information provided by the couples on their individual health status, satisfaction with life, roles and responsibilities, use of resources, their issues of concern and goals for the future; and 3.) observations of the dyads, their interactions, attitudes, communications, and adaptations to their current living situations, as well as their apparent abilities to cope as couples.

CHARACTERISTICS OF THE COUPLES

A number of characteristics of the 19 couples interviewed have been noted, including the ages of each partner; the length of time the couples have been married; the numbers of children and their current proximity to their parents; the current types of homes of the couples and their relocation patterns; driving mobility of each couple; the caregiving roles and relationships between partners, and the health of each partner, as it influences the relationship between partners.

Age of the Partners

Initially the intention was that both members of each couple would be over the age of 75 years of age. During the study it became increasingly difficult to find enough couples to fill each cell with this limiting age criterion. In order to fill the requirements for couples with male caregivers at this time in the specified communities, one couple both aged 73 years was included. As well, to find enough couples with female caregivers caring for a male with cognitive impairment, who had not recently been

admitted to a personal care home, or deceased, it was necessary to include a couple where the wife was 72 years of age and her spouse was 82 years old. Another couple was recommended, and during the interview was found to be too young, 65 and 70 years of age, although they met all other criteria and were definitely having increasing difficulty in managing independently in the community. The data collected from the latter interview with the younger couple, have not been included in the analysis.

Of the 19 eligible couples interviewed, the ages of the partners ranged from 72 to 96 years of age, with the females ranging from 72 to 95 years of age, and the males from 73 to 96 years of age.

Table 5 Age Distribution of Male and Female Partners Interviewed and Differences in Ages Between Partners

Years of Age	# Male Partners	# Female Partners	Total	Difference in Age Between Partners	# Couples
70 - 74	1	2	3	0 years	5
75 - 79	3	5	8	1 - 2 years	4
80 - 84	7	7	14	3 - 4 years	4
85 - 89	6	4	10	5 - 6 years	1
90 - 94	1	0	1	7 -8 years	3
95 - 99	1	1	2	9 - 10 years	2
Total	19	19	38		19
Average Age	84 yrs.	82 yrs.		Avg. Difference	3.5 yrs.

Some sixty-three percent (63%) of the partners were 80 years of age and older. The average age for the females was 82 years of age and for the males it was 84 years. In 12 cases, or sixty-three percent of the cases, the male was older in years than the female, in five cases (26%) they were the same age and in two cases (11%) the female was older in

years than the male. Age difference between members of each couple ranged from being the same age to ten years difference, with an average of 3.5 years between partners.

Years Married

The number of years married ranged from 20 to 67 years, with an average of 52 years. Seventy-nine percent of the couples had been married 50 years or more. Of the four couples married less than 50 years, one had been married 44 years, one married later (with both partners being over 50 years of age), and two were second marriages for at least one of the partners.

Number of Children and Their Proximity

Of the 19 couples interviewed, 17 couples or (89.5%) had a total of seventy-one (71) children. Couples reported having no children to having eight children, with the mode being five children. The average number of children per couple interviewed was 3.7 children. Four couples reported a total of five children deceased, one in infancy, two as youth and two as adults. Thirteen couples (76.5% of those with children) reported at least some of their children lived nearby, and of those, two couples (11.8%) reported all their children lived near by. Four couples had none of their children living nearby. The two couples, who had no children, both had nephews who had moved onto their farms and continued to be supportive of them.

Types of Housing, Relocation Patterns

Of the 19 couples interviewed, 15 couples (79%) lived in houses and four

couples (21%) lived in suites, two which were located in elderly persons housing units. Four or 21% had not relocated since being married (two on the farm and two in houses in town), while 12 (63%) had moved off the farm and three or 16% had moved from a house in one town to another location in the same or a different town. Of the 12 who moved from a farm, eight moved into houses in town, two lived in suites in town, one moved their house to town, and one moved into a house in town and later into an elderly persons housing unit.

Table 6 Types of Housing of Couples Interviewed

Types of Housing	# of Couples
Single Unit Dwelling	15
In town	13
On the farm	2
Suite	4
Elderly Persons Unit	2
Apartment Block	1
Triplex	1

It is interesting that those who moved to town from the farm had relocated from four to 30 years earlier. Some retired, while others continued to farm after relocation to town. Two couples were planning moves from their houses to seniors' life lease units and two couples reported that one of the partners had been panelled or had applied for placement in a personal care home. One couple reported that they were considering a move from their house to seniors' housing in the future, but were undecided as to the community they should chose.

Of the 14 couples who had lived on the farm when first married, two couples remained on the farm and 12 couples relocated. Nine couples, 64% of those who had farmed, reported sons were currently on the farm, including one of the couples who had remained on the farm. The two couples without children reported nephews currently living on the farm and offering ongoing support to them.

When reviewing the relocation patterns of these rural couples a continuum emerges, with couples self selecting which steps of the continuum apply in their lives. Rural couples tended to move from a single unit dwelling on the farm to a single unit dwelling in town. The few who had relocated, but not from the farm, moved from a single unit dwelling in town to a dwelling where yard work and household maintenance were less demanding, or were assumed by a landlord. Those who had relocated to a single unit dwelling in town eventually moved to an environment where they had a landlord to take responsibility for yard upkeep as well as household repairs and maintenance. Those who had not moved to supportive living environments, recognized that there was potential for such a move in the future. At the end of the continuum, the couple was no longer able to continue to live together in the community and personal care home placement of one of the spouses became the only alternative.

Driving Mobility

Ability to drive and possession of a vehicle are primary assets to anyone living on a farm or in a rural community. Local bus systems are non-existent and some communities also lack a taxi service. Of the couples interviewed, 15 couples (79%) owned at least one vehicle and had at least one valid driver's licence between the

partners. Two couples owned cars but did not drive themselves and two couples did not have a car or valid drivers' licences.

Considering the 15 couples with driving mobility, both members of four couples drove, six husbands only drove and five wives only drove (Table 6). Of the 12 couples with a male or female primary spousal caregivers, in eight cases, only the primary caregivers drove; in one case both partners still drove, in two cases neither drove (female caregivers) and in one case the male was the primary caregiver, but only the wife (recently ill and younger) drove. Several drivers reported that they no longer drove to or in Brandon or Winnipeg. (For distances from communities to these centres see Table 4.)

Table 7 Vehicle Use Among Couples Interviewed

Vehicle Use	# of Couples
Both Partners Drive	4
Husband Only Drives	6
Wife Only Drives	5
Have Car, Others Drive	2
No Car, No Licences	2

Caregiving Roles and Related Health of the Partners

The intent of the study was to interview rural couples with male partners as primary caregivers, female partners as caregivers and couples with both partners providing support to each other. In each of the three types of cases, the perspectives of couples dealing with cognitive impairments and with physical impairments were seen as

important to include. In the end, 19 couples were interviewed, of which seven couples were providing mutual support to each other; six couples had dependent wives with the husbands as primary caregivers; and six couples had dependent husbands with wives as primary caregivers. Two cases with dependent wives experiencing cognitive impairment, and two cases with dependent husbands experiencing cognitive impairment were included. Tables 8, 9 and 10 follow and describe the types of couples interviewed. A key to the abbreviations and symbols used in these tables is shown below as Figure 3.

Figure 3 Key to Abbreviations/Symbols Used in Couple Descriptor Tables

++	To a considerable degree
↓	Decreasing, declining
↑	Elevated
CHF	Congestive Heart Failure
?	Questionable, don't know
#	Fractured
PCH	Personal Care Home
RA	Rheumatoid Arthritis
Ca	Cancer

Health status for those interviewed is drawn from the descriptions given by the couples themselves during the interview sessions and their terminology is employed in the tables below. Seven couples were classified as having no particular primary care giver, with both spouses providing support to one another.

Table 8 Interviewed Couples with No Primary Caregiver

	Husband's Health	Wife's Health	Ability to Manage
C1.	Stroke late '95, uses walker/scooter when out	arthritis ++, cannot walk any distance	neither could manage living on their own
C2.	Angina, poor balance, falls, uses walking stick	stroke '90, heart attack, CHF, ↓ energy	he could not manage on own, either would have to move
C3.	Small strokes last week, weaker leg, diabetes	no identified problems	she could manage on her own, he ? health
C4.	Old # hip, walker since, frail ++, 95 yrs old	less strength, ++, 96 yrs old	neither could manage on own
C5.	Several strokes, ↓ balance, cane, poor hearing and vision	arthritis ++, cane, knee replaced, painful back and joints	he couldn't manage on own, if her health improved she could manage, if relocated
C6.	No identified problems	Hodgkin's Disease in remission, ↑BP, ↓hearing	either could manage on own
C7.	Recent CAT scan, bone scan, previous cancer of prostate years ago	cataract surgery '94, '95, ↓ energy,↓ hearing	either could manage on own, but his health ?

Of the seven couples with no primary caregiver, two were comprised of partners who could each manage on their own if their spouse was no longer with them. Two couples were comprised of partners, of which neither could manage on their own, without the other. In the three cases, health was unstable in at least one of the partners, leaving in question the ability to remain living independently in the community difficult to answer. Two of the last cases would require relocation from the farm, likely to supportive housing if either spouse was no longer able to live with their partner.

Table 9 Interviewed Couples with Husbands as Primary Caregivers

	Husband's Health	Wife's Health	Ability to Manage
H1.	Old cancer of prostate, arthritis, emphysema	Alzheimer's Disease, uses cane	she could not manage on her own, he could
H2.	Previous tumor of abdomen, 3 surgeries, not cancer, heart races	fall 2 yr ago, # hip 9 mo ago, slow recuperating, uses walker	she could not manage on own, he could
H3.	Back problems, bronchitis, ↓ hearing, bilateral aids	hernia/gallbladder surgery 4 mo, slow recuperating, heart problems, ↑ BP	she could not manage on own, he could likely manage on his own
H4.	Short term memory declining	stroke following surgery for cancer of lung 8 yrs ago, dysphasic,	she could not manage on her own, ? how much longer he could
H5.	Heart problems	arthritis, spondylitis ↓ mobility, some bed days	she could not manage on her own, he could
H6.	New heart problems, says minor, soon to go to see specialist	aneurysm 10 yrs ago, ↓memory/judgment, RA++, uses walker	she could not manage on her own, is panelled for PCH, he could manage on his own

Of the couples with husbands as primary caregivers, all husbands could manage to continue to live independently in the community if the spouse was not available, but none of the wives could manage on their own. In two cases, given the health of the male spouse, it is questionable how long he could manage independently, but initially it would appear possible. However, the impact of the loss of a spouse may decrease that ability substantially and these two male caregivers have very little extra energy to deal with additional physical or emotional challenges.

Table 10 Interviewed Couples with Wives as Primary Caregivers

	Husband's Health	Wife's Health	Ability to Manage
W1.	2 hips replaced, diabetes, recent tests for cancer of prostate	no identified problems	he at his best due to her, could manage on his own for while, she could manage
W2.	Small strokes, bad fall 10 days ago, hernia surgery 5 weeks slow recuperating	occasional phlebitis in legs	he could not manage on own, she could
W3.	Alzheimer's, incontinent, no memory, very mobile	no identified problems	he panelled for PCH, she could manage
W4.	Blind 6 mo ago, cancer bowel 1½ yr ago, previous cancer prostate	no identified problems	he much learning to manage on his own ?, she could
W5.	Parkinson's, uses walker, poor balance	no identified problems	he not manage on his own, she could
W6.	Weak legs, ↑ small strokes, ↓ memory, gets lost	old stroke, glaucoma, diabetes, fibrillation	he not manage on his own, she could

Considering the six couples with wives as primary caregivers, four husbands could not manage on their own, one could initially and the other could manage independently if he could learn to function independently while blind. In all cases, it appears that the wives could manage independently without the husbands.

It is interesting that the health of the male caregivers appears to be generally poorer than the health of the female caregivers. What is not clear is the impact that looking after the female spouse has contributed to the male caregiver's health status.

COUPLES REPORT

Couples were asked to answer a series of questions as a couple, then a set of questions was administered to each spouse individually, although they remained in close proximity to each other. The questionnaire is found in Appendix 3. No suggestion is made that responses in either situation were without the influence of the presence of the partner. The distinction between the two sets of questions, is that the initial situation has both answering together and later each answers on their own. Generally, as partners knew they would be asked the same questions and they did not answer for a spouse.

Questions responded to as a couple sought input as to years married, previous residence, roles within the marriage, community service use, health care service utilization, evaluation of services used, supportive individuals, suggestions for improving services, and issues of concern. Individually partners were asked how they would describe their health, and that of their spouse, their mobility, functional status, need for assistance about the house, use of physician services, use of other health care services, satisfaction with life, goals for the future, most important resource, and adequacy of income. It should be noted that while all aspects of the interview contributed to understanding the couples, all the narrative passages included in the findings have been derived from the couple portions of the interviews, where partners negotiated their responses and answered as a dyadic unit.

Health Status Ratings

Each partner was asked separately how he or she rated his or her own health and that of his or her partner. Four partners were unable to answer, leaving 34 respondents

answering these questions. When rating their own health, 25 or 73.5% felt that their health was good, very good or excellent; 17.5% felt their health was fair and about 9% believed their health to be poor (Table 11).

Table 11 Couples Reported Health Status

Reported Health Status	Own Health	Spouse's Health
Excellent	3	0
Very good	10	13
Good	12	7
Fair	6	9
Poor	3	5
No answer	4	4
Total	38	38

Generally, considering the chronic conditions and acute episodes these seniors were experiencing, they may have tended to overrate their health status, compared to that observed during the interview. However, Mossey and Shapiro (1982) found that self-rated health is an important predictor of mortality, independent of the subject's level of objective health status. Studies often specifically ask that individuals compare themselves to others their own age, in order to rate their health (Mossey & Shapiro, 1982). Seniors generally tended to compare their health to other seniors, as illustrated by their responses which were often qualified with "good or very good 'for my age'". Further, Kaufert et al. (1979) caution that when comparing self-rated health with objective evaluations, discrepancies may be due to either the senior or the performance evaluator confusing what the subject normally does with what they are capable of doing,

resulting in differing opinions.

Of the 34 spouses that were able to respond, 9% rated their health as excellent; 65% rated their health as good or very good; 18% rated their health as fair; and 9% rated their health as poor. When partners reported the health status of their spouse, they tended to rate the spouse's health lower overall, with none rating the health of their spouse as excellent; 59% rating the health of their spouse as good or very good; 26% rating their spouse as having fair health; and 15% rating their spouse as having poor health.

Generally caregivers thought they were healthier than the care receiver, which is to be expected. However, it is noteworthy that those receiving care tended to rate themselves healthier than their spousal caregivers rated them.

Satisfaction with Life

To gather information on how these couples rated their satisfaction with their current life situation, each partner was asked about his or her satisfaction with life in general at present. A range of possible answers was supplied – excellent, good, fair, poor or bad. Of the 38 partners involved, five were not able to answer this question. Considering the remaining 33 respondents, three or 9% rated their satisfaction with life as excellent; 26 or 79% rated satisfaction with life as good and four or 12% felt their life satisfaction was fair. Those reporting fair also showed some frustration with their current health status. Those reporting excellent tended to be very positive upbeat individuals, two were primary caregivers and one stated 'excellent' because of her strong faith in God.

Adequacy of Income

When asked how well their current income met their needs over the past year, 33 of 34 (97%) responded adequately or very well. Nine couples out of 15 gave the exact same answer to this question. Only one partner responded 'with some difficulty' (the spouse could not respond). The struggle, in this case, was the upkeep of a large aging house and payment for services to assist with cleaning and laundry (wife with Alzheimer's Disease, Home Care well involved). One couple stressed that for the first part of the year medication costs with the Pharmacare program were very high, over $320 per month, which was difficult for them. That burden had decreased in the recent past, as the deductible of the Pharmacare program had been reached. When asked what they would do with additional discretionary income, most replied that they wanted for nothing and were not experiencing any need; they had decreased their spending as they required less; and they 'did not know'. Others suggested they would likely help out their grandchildren.

Use of Community Services

Couples were asked about their use of community services. They were not asked to translate their perception of their functional status into requirements for services. They were asked what services they used or would like to have available. It is recognized that while couples could readily identify resources that they used, it could be more difficult for them to translate functional needs into needs for supportive resources. Some couples were able to do so and reported this link in their interviews. Others were not as readily able to identify resource needs despite their awareness of their functional

problems.

Generally, couples were well satisfied with the types of services available in their communities, and with the quality of those services. Couples identified a variety of services of particular help to them. Ten couples used the delivery services of local grocery stores. Five couples used this delivery on a regular basis, four used it on an occasional basis and one used the carry out services of placing the groceries in the car. Couples reported that to be able to phone the order to the grocery store and have it delivered was also very useful. Two couples reported going together to get groceries and one reported that getting groceries delivered to the farm was a problem and they were in the process of hiring their cleaning lady to pick up and deliver their groceries to them. A few couples also mentioned the usefulness of delivery by their local drugstore.

Snow removal and lawn mowing were areas where resources were also needed. This, of course, was not a concern for the four couples who lived in suites. Of the remaining 15 couples, four couples hired these tasks done by commercial businesses, three couples hired students, several reported family assistance and others had the help of friends or neighbours.

Three couples reported occasional use of the local taxi. Three of the five communities included in the study, have no taxi and one community has a taxi only in the winter months. One community uses the handivan as a taxi and couples reported using it as such. Three couples reported using the handivan for transportation to and from the adult day program. Several couples mentioned Support Services to Seniors and its help in finding drivers whether for rides to appointments, congregate meals or

out of town for health appointments. Two couples reported taking the bus to see specialists in Winnipeg. (For distances from communities to Winnipeg see Table 4.)

Seven couples mentioned the helpfulness of the local Support Services to Seniors in assisting them to find whatever resources they may require. In several instances Support Services to Seniors had helped them to find an individual to provide household cleaning services. Ten couples had hired help with household cleaning. Six couples reported regular use of cleaning services, while four reported occasional use.

Adaptation involving spirituality and association with faith communities were important for several couples and eight couples reported a close association with the church. A strong faith in God was apparent in discussions with four of the couples, and one couple reported their church family as their most important resource.

Four couples reported making extensive use of the local library for recreational reading or for taped books. A 92 year old stated, "...I had 100 books out of the library in 10 months. That's the way I read". Another couple described their library use:

Interviewer: Do you folks make use of the library?
Hilda: Very much so.
Emmett: Yes, every week. I like magazines, about history and geography. (Emmett holds up The Beaver and Equinox)
Hilda: I'm more for fiction. I had a cataract off and I can see pretty good.
Emmett: This is a good library here. Martha [the librarian] is good.

Several couples suggested that they enjoyed occasional meals at local restaurants; three couples reported buying meals from a local restaurant and taking them home; and two couples reported attending congregate meal programs (one on occasion, one regularly). Two couples had used meals on wheels in the past. Two couples reported the usefulness of their community recycling program and its pick-up service.

Use of Health Care Services

All couples felt that their family physician was an important resource. Of the 38 partners involved in the study, only four had not seen their family doctor in the previous six months. Five individuals had been in hospital, so had seen their doctors frequently. Of those in hospital, one had been in the local hospital, two had been in the regional referral hospital, and two had been in both. Four partners reported seeing the doctor 'several' times; one reported six times; four said 3-4 times; five said 2-3 times; eight reported two visits and six reported one visit in the previous six months. In one instance the husband could not recall for his wife, and she was unable to answer. One couple reported their family doctor was in Brandon and two couples stated that their family doctor came from a nearby community and had clinic hours in their community.

Seven of the couples reported seeing one or more medical specialists, either in Brandon or Winnipeg, in the past six months. These specialists included: orthopaedic surgeon, general surgeon, urologist, diabetes specialist, skin specialist, cancer specialist, and arthritis specialist, As well, five couples reported seeing an ophthalmologist in Winnipeg in the past six months and one couple stated that their ophthalmologist from Winnipeg had travelled to a rural community near them for a clinic. Others reported their ophthalmologist in Brandon had recently retired and they believed they would now have to go to Winnipeg. Eleven couples had seen an optometrist in the past 6 months, usually in their own community or in Brandon. For those who reported that no optometrist was available in their community, some couples described travelling to a nearby community.

Home Care services were opened to 10 of the couples. Four couples reported Home Care on a 6-7 day a week basis. Services included morning bath, dressing and exercises, meal preparation, and/or all night care. One couple used Home Care three times a week complimented by adult day care on opposite weekdays. Another couple had assistance with one partner's weekly bath; two couples reported having a Home Care assessment and receiving respite services on occasion. Two additional couples were currently undergoing the assessment process.

Nine couples had used the services of a dentist, four had seen a physiotherapist, four had used the adult day program (occasionally, or 1-3 times a week), two had used respite services in the form of personal care home stays, four had seen hearing aid suppliers, one had used a chiropractor, one had seen a rehabilitation therapist from the regional chronic psychiatric centre, two received foot care, and one was undergoing nuclear medicine testing. One couple reported having used a hospital bath program which was discontinued in the winter resulting in the need to hire someone to come in and assist with a weekly bath. Two of the couples had a partner panelled or placed on the waiting list for placement in a personal care home. One couple received resources from the Canadian National Institute for the Blind and another received financial assistance from the Department of Veterans Affairs to assist with the costs of medication and household cleaning services.

Couples also reported using a variety of types of equipment to assist them in managing in their own homes. Four couples had put in tub bars, three had toilet rails, two couples were using a tub seat and one had purchased a tub lift. One had purchased

an electric recliner that could be raised to assist one in getting up. One couple had purchased a treadmill for exercise on rainy days or in the winter, another couple used a stationary bicycle. One partner used a motorized scooter about town, two used wheelchairs when outside, six used walkers and eight used canes. One partner used a nebulizer to assist with his breathing and one used a commode; one senior had his own glucose meter for blood testing; and one had special dishes with dark markings for use by the visually impaired.

Support of Family and Friends

Most couples identified their family as a very important support in their lives. In fact, all but one couple credited some member of their family with providing assistance by doing household cleaning, home repairs, snow removal, lawn mowing, chauffeuring, spouse sitting, caregiving, meal preparation, emergency intervention and a variety of other household and personal tasks. Not only were sons and daughters seen as important resources, son-in-laws and daughter-in-laws, grandchildren, nieces and nephews were also praised frequently. Families were viewed as being emotional supports, and were reported as being available no matter what type of assistance may be required. One couple described the assistance of their family this way:

Interviewer:	Are there any other kinds of jobs that you need done that you hire someone to do? Or someone helps with?
Emmett:	Oh, the kids come along here and bring supper or do things..
Hilda:	Everything. The other day supper or pickles or raspberries. They are here quite a bit.
Emmett:	I got to go to Winnipeg for my eye..
Hilda:	Well, they'll take you there too.
Emmett:	They are starting to worry about me driving there.

Another couple described their family:

Interviewer:	When you need help with anything you are not able to do for yourselves, where do you get help?
James:	We do most things ourselves. Oh, the kids have mowed the lawn some and one thing and another.
Interviewer:	When you say the kids, have you got children who are living here in town?
James:	We got 5.
Beatrice:	But we haven't got anybody living in town.
James:	No, we have a son living out on the farm.
Beatrice:	Odd times mows the lawn.
James:	And 2 in Portage. And oldest one's at Flin Flon, and one boy on the farm out here and oldest daughter's in Calgary.
Beatrice:	When they come to visit they always have a task they want to do for mom and dad. Such as ..
James:	And they come with the idea they are going to do it and they do it.
Beatrice:	Such as ..... Make those curtains, or do this.....(motions around the room).
James:	They papered the kitchen here, took the paper off the bedroom one day and we got the bedroom painted.
Beatrice:	That was when they were home you see. They had planned that before they came.
James:	Our family is good to us.

The very presence of family seemed to offer comfort and security to these elderly couples. When asked which resource was most important in helping them to maintain their independence, 10 couples responded 'family'.

Often couples reported that they had 'good neighbours' or 'good friends'. Friends were described as providing social support, assistance with errands, as well as rides to meetings or appointments. Friends and neighbours helped with yard work, supplied well water, shared garden produce, assisted with emergency situations, visited shut-ins, relieved caregivers, did hair care, and provided companionship.

One couple described a situation from the previous winter:

Beatrice:	Well one day last winter when it [the snow] did pile up on the door step, it got very bad, well she [the next door neighbour] shovelled it out in the morning.
James:	The snow was as high as this table. On the door step there. The neighbour girl, she came in there and shovelled it out for us.
Interviewer:	So the neighbours help too if you need a hand.
James:	You like to have good neighbours. If you're a good neighbour, you're like to have good neighbours.
Beatrice:	Because I think she wondered if we could ever get out of that door.
James:	I don't think we could have got the door open. It was up nearly to the screen.
Beatrice:	Her grandma and grandpa used to be there and I was good to them. Because I used to go in there every day, well now it is the granddaughter living there and she has said she would do anything for us. Well, I think she would...

Couples reported linking with friends in person, by telephone, and through the mail. Both males and females reported enjoyment of friendly visitors both in their own homes and over the telephone. One female caregiver stated that after she settled her husband to bed at night, she had eight penpals to whom she loved to write.

The more senior couples reported a decrease in the numbers of long time friends that were still living. Comments included, "...we don't have as many friends now either, so many have died" and "...as a couple we haven't, well we used to have dinner parties with friends...we've had very good friends...but most of the husbands have died..."

The couples who lived in suites, including elderly person's housing units, remarked about the valued companionship and activities within close proximity, since their mobility was often limited. The two couples who were planning on moving into 'villas' in the near future stated that part of the reason for the move was easier access to

the fellowship of their peers. One 95 year old female participant, who reported only putting on her winter coat three times last winter, summed it up by stating, "We like it here, where others are about."

Rural males often reported daily trips 'uptown to get the mail' which also included 'a trip to the coffee shop'. One fellow reported, "I think I missed 4 days last winter, that I didn't go up due to the weather." The females tended to describe ladies groups, church groups or bridge clubs which often filled their afternoons. Couples reported activities such as shuffleboard, cards, day trips, and pool at the local seniors' drop-in centres. Rural seniors spoke of their communities as 'full of friends'. Two couples described their community as a 'caring town'. Another spouse suggested that her husband could still go uptown to get the mail, although he had started to have trouble finding his way home. She stated, "Everybody knows him and his situation. They will all help him to get back home."

Evaluation of Services, Recommendations

Generally, the couples interviewed were very pleased with the services that were available to them and appreciated the assistance they had received from a variety of sources. Those receiving help from families and friends expressed a deep appreciation for the assistance and the support they had received and the comfort they experienced in knowing these resources were available on an ongoing basis. Those using local hospitals were very satisfied with services. One male caregiver stated that while his wife was a patient, he was encouraged to join her for meals, at a very reasonable cost. Overall, couples were thankful for and satisfied with Home Care services, adult day

programs, and respite services that they had accessed. One male caregiver reported "Jane Ross [the Continuing Care Co-ordinator] has been very good to us". Another couple stated "Rosanne [the Home Care attendant] is great, they all are really." One female caregiver expressed disappointment that her husband could only go to a day program once weekly, instead of the previous three times a week. She believed that he had become too difficult for the program personnel to manage on their outings. Although she stated that respite in her home had been offered by Home Care, she felt she had a better break and it was better for her husband to be at the day program.

One caregiver stressed her dissatisfaction with services that her husband had received as a patient of a regional referral hospital. The couple stated:

Bertha: I just felt as though I was getting the run around in there the whole time. He was in and supposed to have surgery and they cancelled it 3 times and then when they first said they would have to wait till next week, I said how about letting him come home...Oh, no, they couldn't do that, he would lose his place, and then when Monday came and they said there was no chance of getting an OR, he might just as well come home for a few days. To me that is misusing the taxpayers money. I was very upset! I was also upset at the care! It was right on the chart that he wasn't to walk unattended to the washroom. Then when he asked to have a shower, they gave him a couple of towels and told him where the shower was and sent him on his own. I was very upset about that. When I mentioned it to them, that he was not to be going alone... I said if you don't have time I'll do it and they let me shower him twice, and I didn't feel it was my job, I am not experienced in how to handle things like that in their shower stalls.

Interviewer: Did they seem to be short staffed?

Bertha: I couldn't see that they were.

Brian: They still had lots of staff, running all over."

Access to physician services was important to these couples and three couples expressed appreciation that their family physicians made house calls, which saved a

substantial amount of effort on the part of caregivers. One senior was frustrated with the length of wait that she experienced at her family physician's office in Brandon. Another respondent was concerned that a full flight of stairs had to be negotiated to reach her physician's office.

One participant, who used a motorized scooter, and the two who pushed spouses in wheelchairs voiced concern about access to buildings in the downtown section of town and distress at the often bumpy sidewalks. They took these concerns in their stride, but would have appreciated some attention to these issues, by their communities.

Couples praised the work of the Support Services to Seniors in their communities:

- "You just call Seniors Services and they will arrange for someone to come and help you with whatever you want...whether it is to go shopping, or whatever."
- "I suppose you could say that Seniors Services is very good and helpful in finding different kinds of help. A shoveller in the winter, or someone to mow. We have found help that way, through the Seniors Services."
- "[if you don't have a ride] just tell Hazel [the resource co-ordinator] there is always somebody available to take you. They are very good."
- "If there is anything we need, we can always go to Seniors Services."

Some concerns were raised with the difficulty for those with limited mobility or strength to get their garbage to the dumpster at the end of the block; and the quality of meals on wheels, currently being prepared by local restaurants that were considered 'too greasy', by some respondents.

Most Important Resource

Of the 19 couples interviewed, as noted earlier, 10 identified family as the most important resource in helping them to remain independent and living in their own home.

Two male spouses included their wives in their statements about their families. Three couples felt that their health was their most important resource; two felt that 'ourselves' was most important; two identified Home Care; one stated their 'church family'; and another suggested a healthy lifestyle of 'getting up, eating well and getting going'.

Often couples suggested family or health first and then identified a second resource. Three named Home Care, two suggested financial security, one the adult day program, one stated 'relationships' and two felt that the combination of health care services they were using was very important.

Issues of Concern

Couples showed a concern for the future, as well as for social policies of both the provincial and federal governments. Three couples expressed a concern for the future of Medicare, while two were worried about their ability to pay for health care services in the future; and another couple mused about the future of the Home Care program. Three couples stressed the importance of their pensions and their need to continue to receive this financial support. One couple was feeling a financial pinch in repairing the roof of their aging home. They had used moneys slated for their funeral expenses and they were unsure about how they would meet future financial demands.

Two couples raised the familiar rural community issue of the difficulty in recruiting and retaining physicians. Two couples reported that their ophthalmologist had retired and suggested that now they would have to travel to Winnipeg for this service. Another two couples stated that their family physician came to their community weekly from a neighbouring town and they believed he did not have

admitting privileges at the local hospital. They worried about who would provide medical care to them if they needed to be hospitalized.

One couple suggested that their community lacked seniors' housing and that the only funding for future housing development was 'life-lease' which required substantial personal financial resources. They believed that this had the potential of limiting access to multi-unit supportive housing to those who had considerable savings. They queried how communities without adequate low income seniors' housing would address this issue in the future. One couple felt that they had no option for seniors' housing because they required two bedrooms in order to have Home Care stay with one spouse at night. Another couple stated they had no access to seniors housing because pets were not allowed.

Goals for the Future

Couples were asked what their goal was for the future. The majority, 14 or 74% responded that their goal was to remain living in their own home in the community as long as possible. Whether the couple was experiencing failing health or a daily array of challenges to their ability to cope, they tended to strive to remain together and independent in the community as long as possible. The struggle was stated clearly by an 89 year old male caregiver, of a cognitively impaired wife:

> "Oh, Annie should really be in a home, the personal care home. But, she wouldn't be too happy if we were separated and I like to have her here too, of course. So, as long as we can manage, we'd just as soon die in our own home if we can."

Two caregivers stated that they had completed applications for admission and to undergo the panelling process to place their spouses into a personal care home. In both

cases there had been many years of caregiving (8 and 10 years) and their marital relationship was severely strained by the cognitive impairment of the dependent spouse. Still both caregivers were experiencing some hesitancy with their decisions and discomfort with making this particular choice. Comments included: "Well, um.....I panelled him just in case, something could happen.... so I did that" and "...we [the couple] have looked into panelling Marnie for a personal care home, but we are not sure what we will do when the time comes".

Two couples had recently decided to move into life lease housing units and were awaiting the completion of construction. One couple was exploring options for their next move, possibly in the next year or two. They felt they could not remain in their present community because of limited seniors' housing and declining stability in the health care services currently available. They continued to struggle with when to move and whether to relocate to a nearby rural community or to the City of Brandon.

Shared Wisdom

These elderly couples had experienced a substantial amount of living over their many years of life. Throughout the interviews, they were eager to share their learned wisdom without any particular question to prompt their advice. This advice often addressed their philosophies about life or illustrated their attitudes about living. Comments included:

- "Another thing about being old is this, you are always looking for some excitement. Something to keep you interested." (89 yr old)
- "Do as much as you can, as long as you can." (92 yr old)
- "This is one very important thing, for seniors to feel needed. And we are blessed that way because our family makes us feel needed." (81 yr old)

- "Sometimes you have to get used to depending on others." (95 yr old)
- "I've noticed that even though they may be well off financially, seniors sure hate to spend their money." (78 yr old)
- "We pride ourselves in shopping at home." (84 yr old)
- "When you get older your reflexes slow down, everything slows down. Getting older is not the golden years." (82 yr old)
- "These are the golden years." (78 yr old)
- "Teamwork, that is what marriage is all about." (88 yr old)

OBSERVING THE DYADS

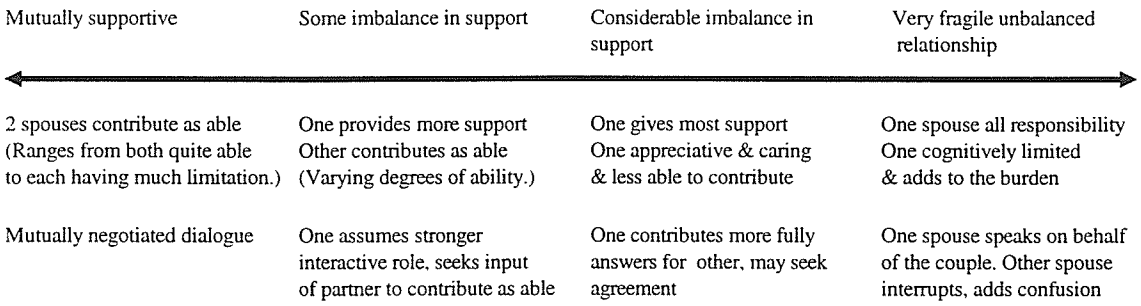
Each of the couples interviewed was unique. Each couple or dyad was a unit, comprised of two separate entities, a husband and a wife. The sum, that is the couple unit, was found to be greater than and different from its component parts. The pattern of responses and the adaptation of each couple to their particular living situation was the aggregate of two separate individuals, with the aggregate being more than what each individual could have accomplished or managed on his or her own. The inter-dependence of the husband and the wife and the influence of the spouses upon each other was noted as each partner contributed to the overall content of the dyad interview. Charon (1989) describes interaction as actors taking each other into account, communicating to and interpreting each other as they go along. Kenny (1996) describes the interrelationship of the couple and has developed a model of non-independence in dyadic research. He suggests that in addition to compositional effects or the similarities between partners in a married couple that influenced their initial pairing, there are three other sources that produce non-independence in dyads. These include: 1.) partner effects where the behaviour of one partner at a point in time influences the other person; 2.) mutual influence, where partners mutually influence each other over time, one

partner influences the other partner and then is in turn influenced by the second partner and 3.) common fate, where both partners are exposed to the same causal factor (such as the interviewer's presence), which influences both of them at the same time.

The interviews with these couples were complex because at times interaction occurred between the couple to jointly negotiate a response. It was particularly interesting to note the tendency for the response to become that of a unit, a single entity, communicating with the interviewer.

When analysing the dyadic responses, a continuum appeared to emerge, along which the couples, who were interviewed, could be placed. It must be remembered however, that observations of interaction in interview situations cannot be expected to fully depict the couples' everyday living patterns.

Figure 4 Continuum of Spousal Relationships of Frail Rural Elderly Couples



At one end of the continuum were the couple units who were supportive, and stable. They tended to function with flexibility and through negotiation. These dyads allowed for the unique characteristics of the partners, with each spouse conscious of, and committed to, the existence of the unit. A positive energy or synergism was

generated within the relationship of the supportive couples. Webster's Dictionary defines 'synergism' as the 'co-operative action of discrete agencies such that the total effect is greater than the sum of the effects taken independently'. Each partner supported the other such that their strength as a unit was enhanced to manage beyond what either could accomplish individually. The spouses at this end of the continuum ranged from both being quite active and physically well to both being quite limited and requiring support. The relationship was one of mutual support, each partner contributing as fully as he or she was able.

At the other end of the continuum were the dyads who were unable to manage or to communicate as effectively, often due to a severe cognitive impairment of at least one of the partners. These couple units showed friction, strain and frustration. The relationship between the partners in this type of unit was one of burden for one of the spouses and of confusion for the other spouse, thus severely threatening their potential to continue living together in the community. Their relationship used energy rather than generated it.

In between the ends of the continuum lay the remainder of the couples interviewed. The majority of whom leaned quite heavily toward the supportive and caring end of the continuum, with varying degrees of ability to contribute to the couple unit, depending on the abilities of each spouse. At times the balance was maintained when emotional support provided by one spouse was complemented by the physical contributions of the other spouse. In these cases, the positive energy or synergism noted earlier at the supportive end of the continuum, was also created by these dyads, which

functioned to strengthen the couples and to support them in their efforts to continue living together, independently in their own homes. As the balance within the dyad shifted with increased responsibility for one spouse and decreased ability to support the partnership from the other spouse, adaptation became increasingly difficult and the fragility of the couple relationship became more apparent.

In describing the dyads, their communication processes and patterns, as well as the content of the interviews were analysed. In addition, their descriptions of their roles and relationships with each other, and their perceived ability to cope with their lives and their environments were documented to assist in understanding and describing the single dyadic entity, the frail rural elderly couple.

Communication Processes, Patterns and Content

Effective communication has long been recognised as an important foundation to a successful marital relationship. The ability of each partner to talk freely with the other, to share ideas and opinions in an open and respectful manner, and with obvious consideration and caring for the thoughts and feelings of the other, are attributes which form the foundation of a healthy marriage (Scanzoni & Scanzoni, 1988). All of the couples interviewed had been married for many years, with the average being over 50 years married. The patterns of dialogue of the couple as well as the content of their conversation, during the interview, contributed to understanding the current relationship that existed between the partners. Examples of mutually supportive relationships, with dyads engaging in mutual cueing are provided, as are illustrations of more unbalanced relationships with varying degrees of difficulties in communication.

Supportive Dyads Using Mutual Cueing

Often answers to questions were a running stream of comments back and forth from one spouse to the other, until the response was completed or the story was told. The comments of one spouse served to cue the other spouse and visa versa. For example when one couple was asked about their use of new technology:

Interviewer: Do you use much of the new technology? TVs or VCRs or the telephone.
Ben: No. A lot of time I feel embarrassed when I go into stores, electrical stores with so much stuff, I don't know what it is.
Mona: We don't have a computer, never have had. I'd like to have had help to do the books.
Ben: We have a TV dish.
Mona: Yes, we've had that for quite a long time.
Ben: But it's not so much good anymore because they scramble all the stations. When we first got it we had over a 100 stations on it.
Mona: But we had our certain stations. It wasn't too bad, it's worse now than it's ever been, since..... would it be since the satellite?
Ben: Which?
Mona: They had trouble with the one satellite.....
Ben: Yes. We can't get..... Now I'm involved in buying an update of the system. But it's all American stations and I don't want American stations. And uh.....
Mona: He likes his baseball. And now the baseball is .....not too sure..... anyway, we watch the TV, but we never had a VCR.

At times a conversation between the spouses emerged inside of their response to the question. Noted above in the underlined portion, Mona stops within the conversation to check her facts with her husband.

When another couple was asked about congregate meals in their community, this was their dialogue, as each partner contributed to many of the statements in an add-on fashion to provide an overall response:

Interviewer: Who puts them on? Who does the cooking?

Ted: They have a crew there.
Nora: It used to be all volunteers, but they do have ...
Ted: a cook...
Nora: they've hired.
Interviewer: Do you pay for the meal when you go?
Ted: Yes.
Interviewer: Do you sign up in advance so they know how many are coming?
Nora: Yes, she usually phones
Ted: the night before
Nora: during the week.....first of the week.
Ted: It is the third Thursday every month.
Nora: It has been kind of disappointing this last month you see, some say they are coming and then they don't show up. It is hard for them to know how much to prepare.
Ted: The price is reasonable. All they were charging was five dollars for a meal all you could eat. You helped yourself. If you went short it was your own fault...

This same pattern of dialogue was also frequently apparent when a couple told a story or relayed the description of an event or of a particular situation. When one couple was asked about the Home Care service they received they described the situation together. This couple cued each other, filled in each others gaps and on occasion one partner restated what the other had said in agreement with the comment.

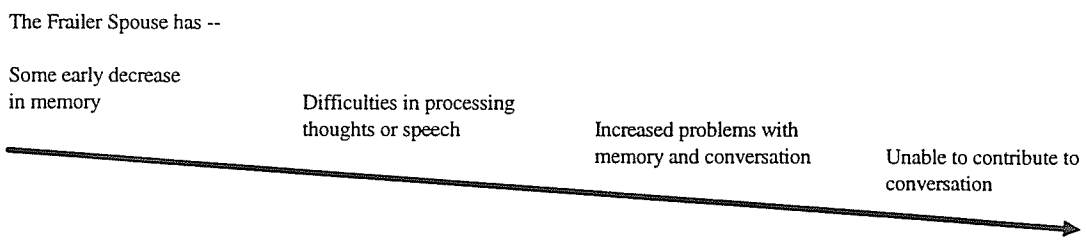
Interviewer: You have Home Care each day?
Gloria: Yes.
Wayne: Twice a day.
Gloria: Twice a day. An hour ..
Wayne: at noon and at night.
Gloria: At noon it should be 10:30 to 11:30, but she gets here.....she has so many, we were the fifth today, this morning. She was pretty late here, so sometimes it is 11:00 to 12:00. And then it is usually 4:30 to 5:30.
Interviewer: When she comes does she prepare the meal for you?
Gloria: No, I sort of see..... that is .....something's..
Wayne: started.
Gloria: Started. Cause you can't make a meal in an hour.
Interviewer: So you start it Gloria? Does she do the rest and finish up?
Wayne: She sets the table and gets the food to the table.

Gloria: And cleans up the pots and pans and that is great! And then I have.. I started again. That I go out 3 hours every Thursday from 3 to 6. I drive myself, but I haven't been up to going a couple of times. I'd just as soon stay at home.

Dyads With Difficulties in Communicating

On occasion, partners had difficulty in communicating with each other and with the interviewer. Five of the couples had one partner that was cognitively impaired. Their communication patterns ranged from a substantial ability to communicate, despite a considerable degree of short-term memory loss, to a complete inability to participate in the interview. Kaufert & Kaufert (1984) apply the term trajectory to a disabling condition. They suggest that the trajectory will vary with the characteristics of the condition and their interaction with the characteristics of the individual. It is conceivable that a trajectory can be developed for dyads with a partner experiencing cognitive impairment that has an impact on the dyad and its ability to communicate. Figure 5 illustrates the trajectory along which these five couples, with one cognitively impaired spouse, have been placed.

Figure 5 Trajectory of Dyads With Difficulty Communicating



One couple was experiencing an increasing degree of difficulty, as the husband's short-term memory was showing considerable decline. When asked about

visits to the eye doctor the response was:

Interviewer:	What about an eye doctor?
Janet:	I have been going to Brandon to Dr. Rawlings. He is retired and he recommended that I go to a nearby community now. I have glaucoma and he says I shouldn't need attention until March so I guess I'll go to this nearby community then. Roger has been to several different ones and now he is going to this nearby community and got his glasses changed recently.
Roger:	I need new glasses because these are getting weaker.
Janet:	He got them changed a couple of months ago, he shouldn't need them.
Roger:	You say I don't need them?
Janet:	(Raises her voice.) I say you shouldn't need them so soon. (Lowers her voice.) He has had problems with one eye and had an implant.

In another community, a couple had experienced substantial difficulty in communicating for some years, since the wife's post-operative stroke. Early in the interview, when the husband was describing Sheila's life, she made efforts to contribute.

Arthur:	She was a teacher. She lived here and her husband died and she taught for a while and she...
Sheila:	5. 1,2,3,4,5.
Interviewer:	Five children?
Sheila:	Yes.
Arthur:	Three in Winnipeg.
Sheila:	And Brian
Arthur:	Edmonton
Sheila:	And and
Arthur:	Gladys. Where's Gladys?
Sheila:	yah
Arthur:	Where's Gladys?
Sheila:	Sancuvr. [Vancouver]
Arthur:	You got it out!
Sheila:	Well you can.

Later during the interview, without any prompting from a question, Sheila spoke again:

Sheila: 5, 5, 5
Interviewer: Five children?
Sheila: No.....
Interviewer: Five?
Sheila: England
Interviewer: English?
Arthur: She used to know five languages, but not no more.
Sheila: German, and.....Polish
Arthur: English, Polish, Ukrainian,
Sheila: And the other.
Arthur: But they all faded out now.
Sheila: 5
Arthur: They all faded out.
Interviewer: Is it easier to write Sheila? Can you write sentences?
Arthur: No.
Sheila: Why yes. Very good.
Arthur: No. She can't answer you on paper.
Sheila: Broke.
Sheila: Book. (Sheila holds up a tattered speech and language workbook)
Arthur: That is her book.
Interviewer: You practice do you Sheila?
Arthur: Home Care gives her about a half an hour or an hour on that in this reading, but it don't want to stick.
Sheila: Aw come on. Come on. Come on.
Arthur: I know it don't stick. I should say stick or remember. It does not stay.
Interviewer: (Looking at a disagreeing Sheila, who is shaking her head) You feel it helps some?
Sheila: Oh, yes.
Arthur: It helps a little bit but I mean it don't.. If I told her to write something she couldn't write it.

Sheila was dysphasic, from a post-operative stroke years before, but the dialogue shows Arthur's limited understanding of the stroke and the resulting dysphasia. Arthur does not understand that Sheila's difficulty in speaking is not due to an inability to understand what is going on around her, or what is being said by others. He believes that her difficulty in communicating is due to an inability to remember, when it is

actually related to her cognitive ability to convert her thoughts into words, especially under stress. Sheila showed great patience and continued to smile while she disagreed. Arthur became agitated when she disagreed with him, or he could not decipher her comments quickly. For example:

Arthur:	Our Home Care, what we have, have been pretty good with helpin her along in her speech and her help. They have been pretty good.
Sheila:	5, 5, 5. Home.
Arthur:	3 have homes here.
Sheila:	No. Winnipeg.
Arthur:	Are you talking about the kids?
Sheila:	Nothing.
Arthur:	Sometimes it is very very very hard for me to understand.... sometimes what she wants to come out with..... Sometimes I figure it out. ..... Sometimes I don't figure it out. Sometimes one word tells me what she wants, sometimes I can't figure it out.

Arthur had a tendency to believe that because Sheila had difficulty in speaking, she had not understood. It was apparent that she understood more than he realised, but the true degree of her understanding could not be determined in light of his impatience.

In another situation, the female spouse exhibited a considerable degree of cognitive impairment due to dementia. Before we started, Matthew, the husband, had offered to get his wife her hearing aid and include her in the conversation, but she had flatly refused. However, as the interview began she made the occasional statement. For example:

Interviewer:	Where did you live before you moved to this community?
Matthew:	I was in the airforce for 5 years, and we lived in Edmonton, that is I had living out privileges.
Annie:	One cup of water, one cup of milk, I would like.
Matthew:	Just a minute. (Matthew got up and got her two cups, filling them as requested.)
Annie:	I see you are left handed.

Interviewer: Yes.
Matthew: Before I was in the airforce my home town was Broadview SK, Annie and mine and I was brought up on a farm there. I was born in the States, my father immigrated from Norway and he worked in Idaho and my mother was born in Montana.
Annie: Do you know Melanie Anderson of Melita, Manitoba.
Interviewer: Yes, Annie.
Matthew: Anyway my parents moved to Saskatchewan.
Annie: My granddaughter takes voice lessons. Did you know that?
Interviewer: No, I didn't.
Matthew: Annie.....

This husband was very patient, although he expressed some degree of frustration, he showed much caring for his wife and much tolerance of the current situation. He made it very clear that although he knew she should likely be in a personal care home, he had no intention of being separated from her.

In another interview, the wife invited a neighbour friend to come and 'visit' with her husband to keep him busy while the interview was taking place. Her husband was diagnosed with advanced Alzheimer's Disease and was waiting for placement in a personal care home. As a result no dialogue was noted between the partners of this couple. However, the comments of the wife made it apparent that her husband had suffered from Alzheimer's Disease for at least 8 years and he was no longer able to participate in a conversation in any meaningful way. She chose not to include him because she felt that he would only become upset, with no useful outcome. Therefore, the interview was conducted with the wife acting as proxy for her husband.

The communications of the couples during the interviews, with each other and with the interviewer created an image of the relationships and roles of the couples, as well as of their abilities to cope with their current situations and to remain independent

in their community. It is important however to recognize that the interviewer observed a very short segment of the life of the couple and conversed for a very short time. While it is assumed that the interview reflected the relationship to some degree, it must be recognized that this may not be the case and caution must be used in any subsequent analysis.

Roles, Relationships and Ability to Cope

The uniqueness of each couple seemed apparent as they discussed their roles and relationships. Their methods of communicating, their descriptions and their actions provided some insight into the current relationship of each couple interviewed. The strength of the relationships and the energy of the couples, as they faced the future, seemed to depict some of the ability of the couples to cope with the world in which they lived. An amazing energy between the couple or synergism was apparent in varying degrees in many of the couple relationships. Despite the fact that often health status was waning and the ability to do for themselves was declining, the energy, generated by the relationship, and the strength that it created, supported the couple in managing together, when continuing on as individuals would not have been possible. Often partners acted in a complementary manner, supportive of each other both physically and emotionally. They created a whole unit, a couple unit, that could function independently, when separately the spouses would have been much less able to continue to live in the community.

Most often the wives continued in their traditional roles of making the meals and taking care of the house, while the husbands reported doing yard work, gardening

and occasional household chores. In situations where wives were no longer able to vacuum, often the husband assumed that role. Frequently it was reported that husbands helped with dishes and some fetching of groceries from the store. When health did not permit a spouse to continue with his or her traditional role, the other spouse often assumed that responsibility if they were physically able to do so. Otherwise, the task was hired out or family filled the role. If that role included the provision of assistance with personal care, often a combination of the spouse and Home Care responded to this need.

It is interesting that the degree of comfort with the non-traditional roles, seemed to be influenced by the amount of experience a spouse had had in that area earlier in the marriage. For example one elderly male caregiver reported distress with always being expected to determine what the meals for the day should be. He felt the planning was far more stressful than the actual preparation. Another female caregiver did not hire out the yard work because it had always fallen to her even on the farm.

Interviewer: So you do the upkeep of the house, the housekeeping, the laundry and the meals.....

Agatha: The gardening and the lawn and everything. I must say that ever since.....He was a farmer and on the farm he never ever helped with the gardening or anything either, you know, and since we moved here he never did either. I've always done it.

She carried on with it, because it had always been her job. However, she now was also primary caregiver to a severely impaired husband:

Interviewer: Is he able to dress himself?

Agatha: I get him up in the morning, I bath him, shave him, dress him, everything.

The situation had changed and she continued to assume a growing number of responsibilities, which in turn increased the fragility of the couple relationship. This wife reported that she had just completed an application to have her husband placed in a personal care home when a space became available.

Some couples demonstrated a melding of their division of labour that had emerged since retirement, with increased availability of time for one or both of the partners. Many couples had become quite egalitarian in their approach to roles. For example when one couple was asked about the roles and tasks that each of them assumed they replied:

Interviewer:	Who does what?
Robert:	Well, I do a lot of the outside work. Betty looks after her flowers, but the lawn and the rest of the garden is my responsibility. She helps too but..
Betty:	You do the most of the back garden, I do the front.
Interviewer:	How about household tasks?
Betty:	Well..
Robert:	I do the vacuuming usually.
Betty:	He does the vacuuming. The reason he did this is that 2 or 3 years ago I had cancer and I was in hospital from August until December and he got used to doing all the things around the house.
Robert:	Well helping you after we got home too.
Betty:	Yah, he even likes to get in the kitchen and I was getting annoyed because he was getting in the kitchen and I said oh, that's my job. He said well I like doing it too so.....(Chuckles)..And so he's good at no matter what it is in the house...He's good at it.
Robert:	Well, I won't say I'm good at it but I can do it. (Chuckles)

They were generous and considerate of each other in their description of household tasks, reflective of their egalitarian approach to marital roles. It is noteworthy in the dialogue above, Robert speaks of when 'we got home'. He appears ot have experienced Betty's hospitalization as part of the couple unit.

A similar considerate pattern of dialogue, was noted when this couple was asked about the financial responsibilities of each of the partners.

Interviewer: How about paying the bills and that sort of thing?
Robert: I do that, so far. It's just that I've always done it. It's not that Betty couldn't do it but...She doesn't want to be bothered.
Betty: Well I know how if I had to, it's just like the shopping. Robert was used to doing it when I was sick and what not and now I just make a list and ....Oh, I'll go down once in a while and do the grocery shopping, but mostly I make a list and Robert goes down.

In this pattern of adaptation, there is role reciprocity, and although each partner has particular roles, the other is informed and recognised for his or her potential ability to carry out the other's responsibilities if necessary, for the unit to function.

The division of labour very often resulted from the approach that each partner assumed what they were physically and mentally able to accomplish, as noted below. This excerpt also illustrates the impact of the interviewer on the interview as she initially had to ask several questions to get the conversation flowing. The impact of the interviewer on the dialogue of the couple is also shown through the underlined comment of the wife.

Interviewer: Around the house and within your marriage do you each have tasks around the house that you assume?
Ted: Oh, we work together. No, we work together.
Nora: What one can't do the other does.
Interviewer: Who largely does the cooking?
Nora: I do.
Interviewer: And how about housework?
Nora: Well, Tom usually does the vacuuming, the last while anyway since..
Ted: Oh, I can do the dusting too if I have to you know. If things need to be done I'll do it.
Interviewer: And how about the laundry?
Ted: The lawn.....well ... my great-grandson does that.
Nora: Oh, no she said laundry.

Interviewer: It's okay, I'm interested in both. So your grandson does the lawn.
Ted: He likes the pocket money. Dad got the lawn mower for him and so he has to go to pay his dad back...(Ted digressed in a litany on his past life and his wife responded.)
Nora: Wait till you get the next question....This lady has questions to ask...
Interviewer: Are there other tasks.. Who does the grocery shopping?
Nora: Well we both do it.
Interviewer: How do you go about it?
Nora: Usually if he is going down town in the morning and I send the list with him, well what he can carry home, or what we need right then. I try to get an order once a week.
Interviewer: Do you phone and they deliver?
Nora: Sometimes, but usually if I can, I go down and get it myself.

The tone of this interaction was one of support and caring. Although the wife took some lead, and her words could be taken as harsh, they were not and she spoke in a considerate and respectful manner. This couple appeared to generate energy as they talked with the interviewer. There was a warmth between them, a concern for each other and a mutually supportive attitude toward their life together. Theirs was a jointly constructed description demonstrating their role reciprocity and interdependence. It is important to know, that while they sound very mobile and active, their energetic dialogue does not reflect their degree of mobility and physical energy. In reality, each of them moved very cautiously, obviously with some discomfort and considerable determination. However, it does reflect an energy between them which adds to their ability to manage. This couple managed better together than either of them would have managed on their own, and the degree that one spouse supported the other changed according to which spouse was experiencing the better health at any particular time. At this point the substantially older male spouse was caring for his wife who was having difficulty recuperating from surgery months earlier.

The continuum that evolved ranges from the successful adaptation with complementary communication patterns of the mutually supportive couple to the fragmented, or agitated dialogue and unsuccessful adaptation of the couple with a fragile relationship. The following examples depict a range -- from the first excerpt which shows a couple who also has a plan that works well for them, to the latter couples who are experiencing increasing imbalance and fragility in their relationships.

Mutually Supportive Spousal Relationships

Interviewer: Do each of you assume certain roles in your marriage and certain tasks and responsibilities that you each tend to?
Louise: Yes, Conrad looks after the floors for me, the vacuuming and washing and such like. I look after the meals. We both do dishes, so it is very convenient. He helps me with the laundry.
Interviewer: How about the yard work?
Conrad: We both work out. She likes working in the garden and I do too but the last two years I haven't done the mowing. I have some arthritis problem so I hired it to be done...

And:

Interviewer: How do you manage with groceries. What sort of a process do you use to get groceries?
Louise: I like to do my own shopping. Conrad drives me to shop. I don't go uptown as often as he does so if it is just milk or something he goes.
Conrad: She's a great shopper.
Interviewer: Sounds like great team work to me.
Louise: Well, that's what marriage is all about.

The tone here is again supportive and caring. Each partner appears to give and receive support from the couple relationship, a feeling of strength within the unit results. However, what is not obvious in the dialogue is the fragility of their living situation as each of the partners is 88 years old and the husband has recently undergone a CAT scan and a bone scan, which has caused them great concern about their future.

Unbalanced and Fragile Couple Relationships

Relationships were noted, where one spouse assumed the majority of the responsibilities, and the dialogue offered insight into the couple's existing relationship. Sometimes frustrations were apparent, as well as caring and concern. One couple was struggling with the continuing decline in the health of the male spouse.

Interviewer: What are each of your roles in your marriage and around the house. Who does what sorts of tasks?
Brian: Now or in the past?
Interviewer: At this point in time.
Brian: Bertha is doing everything.
Bertha: I have to admit that Brian is not really capable of doing too much. He winds the clock, and he sometimes unloads the dish washer and that is a big help. And he helps me shell peas.

In another situation, health difficulties had been placing a strain on the couple for a longer period of time, yet the adjustment to chronic illness had not taken place to any appreciable degree. In this situation, the male partner had recently become blind.

Interviewer What are each of your roles in your marriage and about the house in terms of who assumes which responsibilities and chores?
Jeffrey: Well things have changed a lot. This is, the way things are now would not be relevant to much. The wife's doing the biggest percentage. I do what I can.
Allison: Jeffrey has had troubles since December..
Jeffrey: I'm a good dish drier.
Allison: He helps with the dishes.
Jeffrey: And I help with the garden. I weeded my potatoes and took out most of the plants before I realized what I was doing.

In this dialogue Jeffrey became quite sarcastic and cutting with his last remark about pulling out the potatoes. His frustration and feelings of uselessness were apparent. In the following excerpt the frustration of the husband is even more apparent.

As well, the impact of the interviewer is noted.

Interviewer: How long Jim, have you been having problems with your eye sight. December, 19 .....
Allison: '95.
Interviewer: So, you haven't been long without your eyesight.....
Jeffrey: That's a long time, lady.

In another situation, a male primary caregiver was providing a substantial amount of support to an ailing wife. The difficulty, that they were experiencing in adapting as a result of the declining health status of the wife, is quite readily seen.

Interviewer: Do each of you have particular roles that you assume within your marriage and your household?
Agatha: Edwin does it all for the last two years, since I fell and hurt my back and then last winter my hip broke on me.
Edwin: I'm chief cook and bottle washer.
Agatha: He's also vacuum man.
Interviewer: Agatha, you fell two years ago and then last winter fell and broke your hip?
Agatha: Well I don't know that I fell and broke it or if it just broke and let me down, but it broke about nine months ago. I am in my ninth month trying to recuperate from it. I was just getting over the hurt and twisted back from when I fell. It is hard when you're not used to being sick. I have glaucoma too. We are going to Winnipeg to the eye doctor soon. It is a hard long trip for me. Makes a long day.
Interviewer: I'm sure.....Edwin, you make the meals, and do the cleaning?
Agatha: He does everything. I'm just an object, like an ornament.
Edwin: I get told off sometimes too.
Agatha: I'm not a good patient, I can tell you that, I'm not a good patient.

During the interviews, the dialogue illustrated the change in roles that the couple had experienced in efforts to adapt to the declining health status of the wife. The role change appears to have increased the degree of imbalance in the relationship. The husband has assumed most of the household duties and the wife feels useless as noted in her comments "I am just an object, like an ornament."

The tone of the dialogue is sharp at times. Each sharp statement seems to influence the next statement. Edwin's frustration is seen in his reply, "I get told off sometimes too." Agatha retorts that she is not a good patient. The dialogue, which shows lack of fulfilment, also appears to have the potential to influence the future relationship in a negative manner. However, later in the interview, Agatha shows her vulnerability as she changes her tone and quietly states "I prefer to stay in our home as long as I have help, but I am concerned for my husband and I would be prepared to go to a home if I got to be too much for him. I can be a bad patient and I fly off the handle." She knows that she gets frustrated and that her anger adds stress to the relationship, which increases its fragility. He responds that he prefers for them to stay together in their own home as long as they can manage. The impact that the tone of the dialogue from one partner on the tone exhibited by the other partner was noted, here, for both an angry exchange and a rather sad resigned exchange.

The dialogue of couples seemed to follow along the continuum from mutually supportive relationships to fragile relationships as depicted in Figure 4 earlier (page 55). Those who experienced a mutually supportive adaptation to their living situation seemed to depict a more positive relationship and a shared energy or synergism between the partners within the dyad. Here, a caring and respectful dialogue occurred. The opposite was true of other couples, where frustration and anger were noted in their dialogue. These couples portrayed a more troubled adaptation and seemed to place added burden on already fragile relationships

Synergism Enhances Ability to Cope

The couples that demonstrated the most success in their efforts to cope, regardless of the difficulties they were enduring, generated a remarkable positive energy. This positive energy, previously described as synergism (page 55) appeared to be created by the co-operative action of two separate individuals which built a force far greater than that which could be generated by either individual in isolation. Frequently it was observed that two partners, were frail and at risk as separate entities, but that as a unit, a dyad, they generated a strength, an energy and a stability that enabled them to continue to live independently in the community.

When one couple was asked if there were things that they would like to be able to do if the opportunity was available, they replied with a rather colourful run-on description of their activities, their relationship and their synergism. The tone of their dialogue builds in energy and enthusiasm as they describe their life together. They describe a busy and eventful life, as a couple, supportive of each other in their interests. Each spouse flips back and forth between 'I' and 'we' on numerous occasions. Then they describe each other's activities and add to each others comments.

Interviewer: Are there things that you would like to be able to do if the opportunity was there?

Emily: You see if we belonged to the drop-in and they wanted to play bridge or 500, we would have to get down there and get back.....

Albert: And you have to rush and punch a clock and be there, and every Wednesday you play bridge and every Thursday you play shuffle board, and every day you do something to keep active. I don't want to be active like that. I want to be active so that I can do what I feel like doing.

Emily. And we have a fair amount of company. There is always somebody coming..

Albert: There is always somebody coming or going..

Emily: and it isn't as though we are sitting here looking at each other.

Interviewer: It is obvious that you each have activities here that you enjoy doing in your own time.

Albert: And we, oh we're involved in the history of the district and so on. Right now we are involved in putting together some things for the Newton school district, for the reunion.

Emily: In fact that's what I'm working on over there with that poster.

Albert: You see I got caught, I went to Ippsy Brandts and he said, "How would you like to help us with this dedication of the school cairn? You know you are the oldest living member of Newton School district." So now I get to get up there and make a fool of myself.

Albert: We read these histories, Riverpark, Battleford, Grantview and all these places around. They are priceless, because we know these people. There are no secrets anymore.

Emily: We don't find time hard to put in.

Albert: No.

Emily: You know there is always something..

Albert: If things get really serious, you know, I can watch professional wrestling..

Emily: Do you know we don't put the TV on until 5 o'clock.

Albert: I just can't stand it.

Emily: Except on a Saturday afternoon if there is golf or a Sunday with some sports that we want to watch. As far as soap operas and that sort of thing we are not interested.

Albert: I wonder why I have cable television, because there is so much that is garbage. And I refuse to watch garbage. There is nothing educational, if I wanted to learn how to rob a bank, I might learn that on TV.

Emily: At our age, if you just want to sit..

Albert: I like to go to the town office and drive them crazy with a question that they can't answer..... I shouldn't do that..

Emily: Albert is a great one on the telephone. Now MTS, I hope they don't go out of business. You don't mind if I talk about this?

Albert: No, you talk about me.

Emily: He visits on the telephone, continually.

Albert: Six calls a day.

Emily: And I think that that is great because he is calling not only his men friends, he is calling his lady friends and..

Albert: Widows..

Emily: Widows, and he spends a lot of time, keeping in touch with all these people.

Albert: These people have nobody, they are lonely and they appreciate somebody to say hello to them once in a while. And I don't do very much visiting at the hospital..

Emily: You used to..
Albert: I used to do a lot of visiting at the hospital.
Interviewer: So you do your friendly visiting over the telephone?
Emily: That's right, that's taking the place of ..
Albert: Well I, not only..... I call guys they might be in Vancouver, or wherever, guys that I've known 60 years ago and lost track of. I think of one, and I call to see if he is still alive. And these guys are so amazed that I would call, they are just flabbergasted. How did you find me? And I say there are ways. Course it is a challenge to find them sometimes.
Emily: We do a lot of reading.
Albert: Agricultural magazines
Emily: Albert reads a lot of farm papers and the Financial Post and that sort of thing.
Albert: Financial Post is getting a little too deep for me. But every once in a while. Oh, and the Plainsman too.
Emily: I keep them for three weeks and they go into the recyclables.
Allan: This is something else, I buy Mother flowers every once in a while. These ones are pretty nearly dead. (He points at a bouquet of yellow and orange lilies in a vase on the coffee table.) She is just about due for some new ones.
Emily: No, they're pretty good yet.
Albert: Well, maybe Saturday. I don't buy them all the time, I go down to the farmers market.
Emily: It doesn't hurt for these men to buy their wives some flowers..
Albert: There is a lady down at the farmer's market..
Emily: But Albert has always done that, brought me bouquets of roses, and..
Albert: wood ticks
Emily: wood ticks, crocuses and stuff.
Albert: It is much better to have these flowers when you can smell them.
Emily: He bought those at the farmer's market, but he has a bad habit of buying them up at the florists for no reason what so ever.
Albert: I walk out with flowers and the guys ask are you in trouble, or did you have a fight with your wife?
Emily: Isn't it funny what a few flowers can do for you?
Albert: I've always done it. Its a habit. Call it what ever you like. It does not enter my mind that I need to celebrate something. If I want to get them on Monday or Tuesday or what ever day of the week, I just go and do it. You got to be a little bit crazy to be like us.

The energy that this couple generates and their mutual support of each other is apparent in their dialogue. They seem to be happy and managing effectively together. It

appears that the energetic dialogue is reflective of the relationship. As well this lively dialogue seems to contribute to the dynamic and mutually supportive relationship.

What is not apparent from the discourse is the health of each individual. When the health of these partners is considered, he had a stroke eight months ago and uses a walker or a motorized scooter and her arthritis only allows her to walk short distances, it is doubtful that either could remain independent in the community without the other. Their strength however is not primarily physical, but is largely emotional, which, in this case, appears to be even more important.

Another couple generated energy through their shared and mutual love of the farm and of nature. When asked if there were services that they would like to have, that were not available they responded:

Mona:	I think in most cases if we want it then .....We used to play quite a bit of crib, and at one time we learned chess. We seem to be able to amuse ourselves. And we've got the outdoors. Oh, yes you didn't mention the garden..
Ben:	Well.....
Mona:	Well, it takes a lot of your time.....
Interviewer:	Vegetable garden?
Ben:	Well it is a good size. Yes.
Mona:	And Ben grows enough potatoes to do all year and we give quite a few away. And then he grows a good patch of corn.
Ben:	It's coming along pretty good now. I've got 2 cobs that will be ready next week.
Mona:	We had one cucumber, a long one I noticed when I was out picking beans before lunch. I just grow..... this year, beans and I've had a few snow peas. And I've..... well the deer ate them, but now they are coming on. When I was out getting the beans, I picked a few snow peas, and I brought them in and I put them on...

This couple also moves back and forth between 'I' and 'we' in their descriptions. There is excitement and energy in their dialogue, which is not reflective of

the challenges that this couple experience. They are both in their mid eighties, he has angina, poor balance and declining eye sight, while she has had a stroke, a heart attack and is suffering from congestive heart failure, so must limit her activity. This couple has remained on the farm despite the realisation that they may be snowed in come winter, the power could go off in the freezing cold, and they are a distance from town if they experience an emergency. A tremendous amount of energy, synergism, is required just to accept these challenges and remain on the farm. This couple has managed to generate that amount of energy, as a dyad. There is no question that as separate individuals, neither of these seniors could have remained on the farm this long. However, they are beginning to recognise that despite their concentrated effort to remain on the farm, the amount of energy required is soon going to outweigh their ability to continue to generate that energy in the necessary amounts. When asked about their future plans, their shared turmoil, yet another drain on their energy, was very apparent.

Interviewer: Do you, in terms of future plans, do you see yourselves as staying on the farm?

Ben: Well, I'd like to.

Mona: And I'd like to.

Ben: Yes. But we have..... not promised..... we have put our names in to the [seniors residence]..... But whether ...

Mona: And that's what we have put our names in ... But we aren't..... we put it there because we think that we might..... well we are going to have to some time ..... we won't be able to drive and we will have to go, but.....its the last ditch.....

This dialogue begins with each partner stating his or her preference, but very quickly moves to a dyadic response, with the use of 'we' prevalent throughout. It gives the impression that the move to a dyadic response generates the strength and energy to deal with this very stressful issue.

Another couple described how they manage his bath. The teamwork required to get the job done makes the best possible use of the energy they are able to create. At this point his bath is definitely a joint effort.

Interviewer: How about bathing?
Wayne: I think I can do that all right..... I use a shower.
Gloria: Before he gets in I put soap under his arms and I put shampoo on his head, and help him in and get the water adjusted. Then he holds the rail with one hand and washes.

Certain behaviours that couples describe suggest that considerate and loving actions between the spouses generate energy and contribute to the stability in the functioning of a couple unit. For example one elderly male caregiver reported that when his confused and agitated wife, who was suffering from Alzheimer's Disease, had difficulty settling down to sleep, he would curl up on the bed with her and sing her lullabies.

> "...She wants my attention a good deal of the time you know, and I put her to bed at night and the afternoon. She always likes to have me lie down with her for a while and 'sing me a lullaby'. So I just.....I am not a good singer, but I can carry a tune and I sing."

A female caregiver spoke of tucking her husband in and playing some of his favourite pieces on the organ while he drifted off to sleep. The interview segment earlier (Emily and Albert) illustrates how the giving and receiving of flowers has contributed to the bond between the partners over the years, and continues to do so.

The question arises -- Is this synergy, this strength and ability to cope the most important contributor to the independence of an elderly couple? Couples discussed health factors, family supports, access to community services and their use of health

care services as contributing to their ability to remain independent in the community. The content and context of their interviews suggest that remaining independent in the community rests on a combination of factors and perhaps the provision of services underpins their ability to cope. However, this ability is also subject to other influences, such as the health of each of the partners and of the relationship within the dyad, including the energy or synergism that they generate within their relationship.

CHAPTER 5 — DISCUSSION

Discussion of the study will include comments on the population and sample, the method, the major findings and the limitations of the study.

Population/Sample

The number of elderly persons and of elderly couples continue to increase in Canada. The awareness of the need to address their health and health care related issues is becoming more readily apparent as governments strive to implement health reform and control health care spending. Health service providers, funders, service users and other interested parties recognize the need to study the types of resources, programs and services that have an impact on the health of the elderly population. This study strives to focus on a specific sector of the elderly population, frail elderly couples residing in rural communities.

The sample was selected from one small portion of rural Canada, and as such cannot be anticipated to reflect the entire population of frail rural elderly couples residing across Canada. It is also important to recognize that those interviewed were selected from communities with a population of 1500 to 2500. This too limits any ability to generalize the results. However, the sample does provide some in depth reflection about the state of living and resource use of frail rural elderly couples, according to their personal reports. Couples, who were interviewed, portrayed a variety of living arrangements including mutually supportive situations; circumstances where the husband was the primary caregiver; and environments where the wife was primary

caregiver. The health status of each partner of the couple and of the couple as a unit also varied and the sample was selected to include situations where spouses were experiencing either physical impairments or cognitive impairments, or both. Couples were open and willing to participate in the interviews and appeared to provide honest and real accounts of their lives.

It should be noted that the age parameters set for the study, were selected to ensure that some degree of frailty was likely to be present and having an impact on the living circumstances of the couple. However, in discussion with the Continuing Care and Support Services to Seniors Co-ordinators, it was found that many young old couples (65 to 74 years of age), with appreciable resource and support needs, also reside in these communities. In addition, the degree of frailty of a couple, or of the individual partners was very difficult to gauge. Some couples interviewed were quite well at very senior ages (85 years and over), but were obviously at risk, in that their health could decline at any time. This was obvious when observing the situations of couples who had just weeks before been in a much more stable situation. The fragility of the health of these partners was a factor, which could neither be controlled nor predicted to any appreciable degree. Therefore, given the advanced ages of the partners, recognition of the potential for sudden unexpected changes in health status of either of the partners was considered to be, in itself, an indication of frailty.

Method

The use of semi-structured interviews was effective in facilitating the discussions with the elderly couples. This allowed for some degree of consistency in

the data collected, while providing an opportunity for unique and individual input. When the involvement of family, neighbours, organizations or agencies was identified the semi-structured interview process allowed for probing and gathering additional detail.

Couples were seen in their own homes and this appeared to be a comfortable and convenient environment for the interviewing process. It allowed for some exploration, by the interviewer, of the importance of the relationship between the partners and their ability to function as a unit in adapting to their particular living situation. As a result the interviewer observed each dyad and documented not only the content of the interview, but the communication patterns, the interaction between the spouses and the discernible living circumstance of the couple unit. In other words, the context of the couple's dyadic interview process was carefully noted.

While much could be learned from each couple about their current situation and ability to cope as a unit, it must be clearly acknowledged that this was a snapshot of the functioning of each dyad. Limitations, as to the degree that the interview itself reflected the relationship of the couple and their ability to function, must be recognized and considered in the analysis of the data collected and the conclusions drawn from it. Further, the living situation of the couple captured during the interview must be cautiously considered in any effort to look backward to the past circumstances of the couple or to project any future states of the dyad.

While saturation occurred regarding the kinds of resources that couples identified, each couple brought a unique living situation to the study. Each couple had

differing experiences and particular methods for dealing with the challenges they faced. Early in the data collection process, it became apparent that the interviewed couples would fit along a continuum which showed spousal relationships and their ability to function as a single unit (Figure 4, page 55).

Major Findings

The study produced a comprehensive list of services and programs used by frail elderly couples living in rural communities. Further, the importance of family and friends as resources (Cantor, 1991; Connidis, 1989; Rosenthal & Gladstone, 1993; Silverstone & Horowitz, 1992) was strongly validated by the couples interviewed. The substantial contribution made by spousal caregivers (Lichtenberg & Barth, 1989; Stoller & Cutler, 1992) was also reinforced and the impact of the relationship between the partners of the dyad was identified as a notable contributor to the ability of couples to maintain their independence.

Community Programs and Services

Overall, couples were satisfied with the variety and quality of the programs and services available in their communities. Services which decreased the amount of energy that a couple had to expend or that lowered their need for transportation were considered very important. Grocery stores were praised for taking phone orders, providing carry out assistance and supplying delivery services. Other businesses such as drugstores and restaurants also provided delivery services. Several communities had yard maintenance services available for summer and winter seasons. Transportation was identified as a challenge by many couples and taxi or handivan services were

considered as beneficial to seniors. Support Services to Seniors were noted as providing transportation for local activities as well as inter-community trips for appointments. With rural communities lacking the advantages of a local transit service, people devised alternative modes of transportation to fill their needs. Seniors also reported using regional bus systems to transport them to larger centres, for medical visits.

A variety of organizations and agencies were seen as important to senior couples. They reported the church, Support Services to Seniors, service clubs, drop-in centres and libraries as supportive resources. Support Services to Seniors were regarded as advantageous to elderly people in that they provided an array of services to seniors and could link them to other resources as required. Generally senior couples were appreciative of the assistance available from Support Services to Seniors and derived a sense of security in knowing that help could be found and someone was available to help them regardless of what their need might be.

Support Services to Seniors appears to be successful in providing a resource to address the sundry needs of seniors. This program is a low cost resource funded by government (Manitoba Health, 1992) and is based upon a philosophy of helping seniors to help themselves. Seniors act as volunteers and providers of services, as well as users of services. They also manage the program and comprise the boards that set direction and govern the organizations. In light of health reform, regionalization of rural health care, and the need to provide services in a cost effective manner, it would seem beneficial to conduct an evaluation of the Support Seniors to Seniors programs. A thorough understanding of the programs could then be used to improve and enhance

these and other services using the template that has been found to have success.

Health Care Services

Numerous health care services were utilized by rural senior couples. Physicians including general practitioners and specialists; hospitals – local, regional and tertiary care centres; the services of various health professionals (optometrist, dentist, chiropractor, occupational therapist, physiotherapist, lab and x-ray technologist); programs such as adult day care, Home Care, respite, congregate meals, meals on wheels, hospital whirlpool baths, equipment loan and purchase; and agencies including the Canadian National Institute for the Blind and the Department of Veterans Affairs were identified as resources which had been used.

While seniors were generally pleased with the quality of services they received, they voiced concerns about linkages and communication with services in larger centres that showed an understanding of rural people and rural ways. They worried about the future of health care in rural communities, the stability of the Home Care program, and the continued existence of Medicare in Canada. They valued those services that saved them energy and decreased their need for transportation, such as home visits by various professionals, Home Care and those adult day care programs that included the provision of transportation.

With the goals of decreasing the amount of energy required by the elderly couple and of addressing their limitations regarding transportation, programming can continue to be created and adapted to better meet their needs. Although stability in program delivery is often difficult in today's world, efforts to build some degree of security in

programming and services for seniors would alleviate considerable stress in their world. Seniors are not looking to become dependent on others or to have others make decisions for them, but rather they seek services to assist and support them in maintaining their independence and that enable them to make their own decisions about their life courses. Their decisions to continue to live together as a couple, interdependent, committed to one another and their marital union, must be respected. Planning for appropriate programs and service delivery must include a concerted effort to understand the needs of the couple unit and provide supports that address the needs and priorities of the couple, as a unit, as opposed to focusing primarily on the needs of each individual spouse.

Family and Friends

Family and friends were mentioned by almost every elderly couple as being a primary resource in their life. Spouses were sometimes identified as family and other times noted in addition to family, but always recognized as having an impact on the living situation of the elderly couple. Family members were credited with doing household cleaning, home repairs, snow removal, lawn mowing, chauffeuring, spouse sitting, care giving, meal preparation, emergency intervention and a variety of other household and personal tasks. Sons, daughters, their spouses and their children were principal resources to most couples. Those couples with no children or few available children, often depended on nieces and nephews for assistance.

Friends and neighbours, social clubs, seniors groups, church congregations and coffee groups were noted as valuable resources to elderly couples. Often these

resources were used by one or the other of the spouses. Few of these groups focused on the couple as a single unit, but they were reported to contribute to the well-being of one of the spouses who could, in turn, contribute to the couple relationship. Church activities, other than ladies groups, tended to concentrate on the family or couple unit. Couples reported less availability of other couples to spend time with, as many of their previous couple friends had lost a spouse and were no longer living as a dyad. The value of close relationships with other couples with whom to share experiences and social times became apparent through their absence. Programs, that bring elderly couples together and focus on the challenges and achievements that they experience, may bear consideration as a beneficial resource to be developed.

Synergism of the Couple

The importance of the relationship between the spouses and their collective ability to adapt as a unit to the increasing challenges that they faced emerged as a substantial factor, that contributed to the success of the couple in remaining independent in the community. In some cases it became evident that while neither partner could have managed on his or her own, as a unit they had developed a role reciprocity and interdependence that supported them in living independently in the community. The jointly negotiated roles and responsibilities assumed by each partner created a single entity, a couple unit. The ability of the partners, individually and as a unit, to adapt to their current living situation appeared to be a strong factor in their success with continuing to live in the community. A continuum emerged with those couples who had developed a mutually supportive reciprocal relationship at one end and those

couples having such difficulty that the existence of the interdependent dyad was at risk, at the other end. In those couples struggling to remain together, usually one spouse was unable to contribute substantially to the relationship and the other partner bore a much greater proportion of responsibility for each partner and for the couple. At the extreme, the imbalance between partners was so great that the ability of the dyad to remain independent in the community was severely threatened. When the couple unit was under considerable stress and the partners were unable to support one another and adapt to their situation, their relationship became quite fragile, to the degree that their loss of independence was imminent. The continuum is shown in Figure 4 on page 55.

The support of family and friends, coupled with the variety of programs and services available were often reported by frail elderly couples to be sufficient to meet their needs. While the occasional suggestion for improvement was made, generally the couples interviewed were satisfied with the resources available to them. Given this foundation of resources which support the couple relationship, it appears that the issue of the independence of couples may be raised to a higher level. Once supports and services are in place, does the relationship of the partners, that is the strength and adaptability of the dyad unit, become a substantial resource to that couple in their later years? If this is the case, families, friends, service providers and seniors themselves must ask: What can be done to assist couples in developing a mutually supportive reciprocal relationship? Further, what can be done to sustain elderly couples in supportive relationships and prevent deterioration of the couple as an adaptive functioning dyadic unit?

Other findings including a list of resources and an evolving theory to describe the factors which contribute to the ability of frail elderly couples to remain independent in rural communities are discussed in the section which follows.

Types of Resources and Evolving Theory

In this study the couples identified a list of resources. In addition, the information gathered lends itself to the evolution of a theory or model, 'The Elderly Couples Independence Model' which depicts the resources and factors which contribute to the success of these couples in continuing to live independently in the community. A case study has been included to demonstrate the data collection method and the findings of the study. The model has been applied to the case study to illustrate the ability of the model to show the living situation of the couple and the factors that contribute to success in living independently in the community.

Supportive Resources

A list of resources used by the 19 couples, who were interviewed, has been compiled in Figure 6. This listing is intended as a tool to assist in organizing and understanding resource use by these couples. It is not intended to be an exhaustive list, but rather a list that may continue to grow over time. It is not suggested that this list be generalized to the population of frail elderly rural couples, but that it be used as a starting point to understanding the resources that these couples reported as being useful and important to them. The list is arranged into three categories: 1.) community services, 2.) health care services and 3.) family and friends. Details on the use of the resources and their importance to the couples were documented in Chapter 4.

Figure 6 Resources Identified by Frail Rural Elderly Couples

Community Services
- transportation
  - taxi
  - Greyhound bus
  - handivan/ &as taxi
- housing
  - single dwelling
  - apartment unit
  - elderly persons unit
  - life lease unit
- organizations
  - Support Services to Seniors
  - church
  - seniors drop-in
  - library
  - service clubs
- community businesses
  - grocery stores
  - drug stores
  - restaurants
  - yard maintenance
  - cleaning

Health Care Services
- physicians
  - general practitioner
  - other specialists
- hospital
  - local
  - regional centre
  - tertiary centre
- Home Care
- adult day care
- dentist
- optometrist
- chiropractor
- physiotherapist
- occupational therapist
- lab and x-ray
- respite at PCH
- panelling for PCH
- DVA
- CNIB
- bath program
- equipment (loan/buy)

Family and Friends
- daughters and sons-in-law
- sons and daughters-in-law
- grandchildren
- siblings
- nieces and nephews
- friends
- neighbours
- social clubs
- seniors' groups
- coffee groups

Evolving Theory

A combination of factors appears to determine the success of elderly rural couples in remaining independent in their communities. Resources include: the community services accessed; the health care services utilized; and the support provided by family and friends create a foundation to underpin the efforts of frail rural elderly couples to remain in their own homes. In addition to these resources, the health of each of the partners, their attitudes and their adaptability also have an impact. Brocklehurst (1987) identifies health, functional capacity, a positive attitude toward health and other resources (social, spiritual, financial and environmental) as being important assets to remaining independent. He further suggests that disability, dependence on others for

activities of daily living and burden on caregivers are important deficits. However what is missing in Brocklehurst's model, when considering frail elderly couples, is the dyad factor, the strength and energy, the adaptability and mutual supportiveness, the role reciprocity and joint commitment which a marital dyad brings to their living situation. The ability of a couple to function as a single unit, to communicate, to build strength and synergy beyond what each could contribute individually, appears to be a powerful asset in keeping frail rural elderly couples independent in the community.

Several factors appear to contribute to the success of a couple in continuing to live together independently in the community. These factors include:

- the wife's health
- the husband's health
- the couple's ability to communicate
- the synergism and adaptability of the couple
- support of family and friends
- use of health care services
- use of community services.

The contribution of each sector will fluctuate over time according to the living situation of the couple. Factors will have an impact on each other and a weakness in one area may cause an increase or decrease in another area. For example if the wife is healthy and the husband is healthy, the synergism between the couples may be very easy to maintain and the use of health care services may remain minimal. On the other hand, if the wife becomes extremely ill, the amount of support from family and the use of services may be increased substantially to compensate for her reduced ability to contribute to the independence of the couple. How these factors contribute, over time, will determine the successfulness of the couple in continuing to live together in the

community.

Each factor is quite complex in and of itself. For example, the degree of health care service utilization depends on the availability of numerous services, the use of those services and the effectiveness of those services in addressing the needs experienced by the couple. As well, this factor will interact with other factors such as the ability, availability and willingness of family or friends to complement the health care services in dealing with the needs of the couple. It is important to note the contribution of often unrecognized factors, communication between the partners and the synergism of the couple. It is also necessary to recognize the capacity for changes in each factor over time. At the conclusion of the case study included below, the suggested 'Elderly Couples' Independence Model' is applied to depict the living situation of this couple. Caution must be used however, in expanding a case study to the living situation of the couple over time. The interview is but a snapshot of their living situation.

Case Study

A case study has been included to demonstrate the application of the theory to an actual case, to show the data collection method and to illustrate the kind of information that was collected about and from a frail rural elderly couple. This couple is representative of those that were interviewed. A review of their communication patterns, their discourse content and their living situation is useful in providing more depth to the picture of one frail rural elderly couple. Some of the details have been altered and pseudonyms used to maintain the anonymity of this couple.

Bert and Teenie Shepherd live in a newer, well kept bungalow. They moved to town 18 years ago, from their farm 10 miles to the south. They have a well kept yard and a very comfortable modern home, with newer furniture throughout it. Pictures of their family sit on the television set and numerous knick-knacks are carefully placed on little wooden shelves attached to the living room walls. A large bay window allows the bright sunlight into the room, creating a warm and comfortable atmosphere. Their home is very clean and tidy and Teenie states that she takes pride in keeping it that way. A walker sits beside the over-stuffed electric lounge chair upon which Bert is reclining. He has been watching television and has the remote control in his hand. He moves the chair to a more upright position to chat.

Bert is jovial, loves to talk and delights in teasing. Teenie is more reserved and anxious to know what the interview is about. Bert is 87 years old, has Parkinson's Disease and fell a year ago which caused some damage to his back. Bert also had prostate surgery two years ago. Teenie is 83, the primary caregiver, and is very mobile. She states that she occasionally suffers from back problems and phlebitis. She has to be more careful than she used to be, but has been very good this summer.

The dialogue of the couple during the dyad interview is noted below. The conversation begins with questions about their history as a couple. Bert likes to joke. A conversation occurs between them, which shows some joint negotiation of response (as underlined). Each spouse cues the other and the two together tell of their move to town.

Interviewer: How long have you and your spouse been married to each other?
Teenie: 57 years last June.
Bert: Too darn long. (Chuckles)
Interviewer: Congratulations.....And how long have you lived in this house?

Teenie: 18 years in July.
Bert: Is that right, it's been that long?
Teenie: Yes.
Interviewer: And previous to living here?
Teenie: We were on the farm, yes.....
Bert: Yes, about 10 miles south of here.
Teenie: We moved here from the farm in '88.

When asked about roles and tasks within the marriage, the impact of the declining health of the husband is noted. Some frustration is seen in Teenie's comment "He doesn't do anything anymore." When Bert agrees and adds that this is a fairly recent occurrence, Teenie softens her tone. Some adaptation has taken place with this couple and they are making efforts to deal with the health status that each is experiencing, and its impact on the dyad. Physical tasks are largely the responsibility of the wife, which now includes any activities requiring the driving of the family car. The husband tries to be emotionally supportive and occasionally uses humour to assist them in coping.

Interviewer: Within your marriage do you each have particular roles and tasks that you assume?
Bert: Not, really.....
Teenie: No. He doesn't do anything anymore.
Bert: Well that's just recently though.
Teenie: Yes, that's just this past couple of years. Well, last year.
Bert: I can't walk.....
Teenie: Well you walk, but not very good.
Interviewer: Do you use a walker Bert?
Bert: Yes.
Interviewer: Did you have some health problems that occurred to bring that about?
Bert: Well, I guess you'd say so....Wouldn't you Teenie?
Teenie: Yes, I would say that the doctor said it was Parkinson's. But he did fall a year ago and cracked a vertebrae in his back.

Bert: Well I have really good health, only thing is I can't walk worth a damn. I eat good and can eat anything, sleep good, can't drink anymore.
Teenie: He had a truck but he doesn't drive anymore.
Interviewer: How about you Teenie, do you drive?
Teenie: Oh, yes, I take the car.
Interviewer: How do you folks manage the meals, cleaning and laundry?
Teenie: I am able to manage those things so far.....

Family is considered a very important resource to this couple, and they take pride in their children and grandchildren. One son resides on the farm and one daughter lives in a nearby community. Family provides transportation, especially if Bert needs to be out and about. The daughter helps with household cleaning and general assistance. When possible the couple use outside services for tasks such as washing windows, mowing the lawn and removing snow. Teenie manages to go for groceries and identifies the help she receives in getting them to the car.

It is of note that this couple constantly moves from the use of 'I' to the use of 'we' throughout their conversation. Bert had the surgery, but 'we' went for the check-up last week. Teenie works in the garden, but 'we' hire out the mowing.

Interviewer: When you need the help of others, who are the people that you count on for help?
Teenie: Family is great..... (She points to a set of pictures from their 55th wedding anniversary.)
Interviewer: Looks like lots of family. What do you have for children?
Teenie: Two girls and two boys. One girl in a nearby community and one in Brandon. One son on the farm and one at Saskatoon. And grandkids and great grandchildren.
Bert: I had an operation in Brandon and family take me back for check ups every 6 months. We went last week..... And we have good friends too that drop by and give us a hand if we need it
Teenie: Our daughter was in a few days ago and gave things a thorough vacuuming. She stops by quite often.
Interviewer: Are there things around the house that you need help with?

Teenie: Well, washing the windows, I have help, Seniors Services finds me someone.
Interviewer: If you need to go beyond supportive individuals, where do you go for help?
Teenie: I look after the garden, but we hire someone to mow the lawn.
Interviewer: Who do you hire?
Bert: Just neighbour kids.
Interviewer: What about snow removal?
Teenie: Well we hire a local business, to do it.
Bert: We don't need to even phone him, he just looks after it.
Interviewer: How about groceries and things like that?
Teenie: I go up and get them. They carry them out from the store. But I can manage when I get here.

In exploring the use of health care services, it is found that the couple uses the local physician, but reports going to a nearby rural community for the eye doctor and the dentist. At this time the couple is not using any Home Care services, but has purchased some equipment to assist the husband with his mobility and his bath. The role of the wife in assisting her husband with activities of daily living and personal care is shown in the following segment. The husband again uses humour to deal with his apparent feelings of dependency.

Interviewer: Are there any other services in the community that you use?.....
Interviewer: How about health care services?
Teenie: Yes, we go to the local doctor and to a nearby community to the eye doctor. And to the dentist there too.
Bert: Yah but I only have three teeth left.
Teenie: You was there this spring cause he had a tooth break off.
Interviewer: How about footcare?
Teenie: You did once Bert.
Interviewer: How about homecare?
Teenie: No. From the Medichair we got one of those things for the bathtub, for Bert like.....to go down into the bottom of the tub.
Interviewer: And how do you like it?
Bert: I like it very good. It works well and goes almost to the bottom of the tub. Teenie helps me get in and out.
Teenie: I do his toenails and finger nails, hair in his nose and his ears.

Bert: She's not a bad wife either.....(Chuckles) She's very good.
Interviewer: Are there any other services that you use?
Bert: Not that I can think of.....
Teenie: No.

When asked about services that they need which are not available, the couple continues to describe their activities and how they manage their world. Each partner speaks for the other, when Bert speaks of Teenie going to the Drop-in, Teenie speaks of Bert being inside more in winter. Speaking for one another flows smoothly in their general descriptions and dialogue. Teenie appears to like to be out and about, but makes a conscious effort to temper that with staying home with her husband as he is much less able to go out. There was obvious adaptation noted here as Teenie has reduced her outings in a calculated manner, to still enjoy those that are most important to her, while reducing the overall number of occasions. Bert responds with acceptance of the situation and appreciation for "being used good". This couple has accomplished a considerable degree of adaptation to their situation, a process that seems to be ongoing.

Interviewer: Are there any programs or services that you would like to have available that maybe aren't in the community but would be useful if they were here?
Bert: Teenie still goes to the Drop-in Centre and plays cards. I did too, but I can't go anymore. I can't walk around good enough to manage.
Interviewer: How is it in the winter to get around? Are you in more then?
Teenie: Well, Bert is yes. If the driveway hasn't been dug out and I want to go uptown, I take the taxi. It is very handy.
Interviewer: Are there congregate meals or meals on wheels available?
Teenie: Yes, they have meals on wheels, they come from the hotels, they take turns. They used to come from the hospital and I think if you have diabetes they still come from the hospital. Every Friday the seniors go to different restaurants and in the winter time they have a Wednesday noon meal that they serve at the Community Hall. Bert doesn't go so I stay with him, but they have good attendance at it.
Interviewer: Do you have things that you go out to?

Teenie: I used to belong to the WI but then I quit that. I go to church, UCW and I used to go everyday practically to play bridge. But I don't do so much. Bert doesn't go out much, so I don't like to go every day.
Interviewer: How do you feel Bert about not being able to get out as much as you used to.
Bert: Oh, I don't know. I know darn well its not that bad. I'm used good and I know that I'm 87 years old and I'm not going to get better.
Interviewer: Do you have friends stop by to visit?
Bert: Oh, hell yes.
Interviewer: Does that make the time pass well?
Bert: Oh, yes, we get quite a lot of company don't we Teenie.
Teenie: Yes, a fair bit.
Interviewer: How do you tend to put your time in.
Bert: Sleeping, and watching TV. Watching sports and the club dancing.
Interviewer: Do you have a VCR?
Bert: No we don't.
Teenie: No we don't.

Again the couple do not respond directly to the question, but the question seems to cue comments about their future plans to move into an elderly persons housing unit. Their struggle in making this choice and unresolved differences are voiced. Bert likes things the way they are, while Teenie is trying to decrease the workload and responsibility she carries. Bert does agree that his mobility should be improved with the move and he will be more able to get out in the community. Their dialogue is concluded with a recognition on Bert's part, that his wife is his most important resource in assisting him to remain independent in the community. Teenie responds that she feels family is their most important resource.

Interviewer: Are there resources that you need or would like to be able to use that are not available?
Teenie: We are planning on moving into the seniors' housing at the end of the street.
Interviewer: Are you looking forward to that?
Bert: Well, she is. I'm not too much. I don't like it anyhow.
Teenie: Well I don't know.

Bert: I like it here.
Teenie: Like last year I couldn't do very much, I had a bad back and went to the chiropractor and then it got bad and the doctor sent me to the physiotherapist. She gave me exercises to do so it helps a bit. I just keep doing the exercises. My phlebitis is also a problem.
Interviewer: Looking at the move, do you feel it will be beneficial?
Teenie: It should be less upkeep and less work. We will have neighbours nearby that can stop in and Bert can get out easier.
Bert: This place is difficult to get in and out with the stairs. The new place is supposed to be better.
Interviewer: What resources or supports do you believe are most important to you in maintaining your independence in the community?
Bert: As long as my wife can look after me.
Teenie: Family, our children are just great.
Interviewer: Is there anything that you would like to add?
Bert: No, I don't think so.....
Teenie: No.

This couple is financially stable and able to meet their needs very well. They have purchased equipment to assist Bert in his daily living including an electric reclining chair and a bathtub lift. Teenie offered to show me the equipment following the interview and I noted the strong smell of urine in the bathroom, suggesting that Bert may be having trouble managing to void and may require more assistance than the discussion identified.

Bert is overweight, and his mobility shows no sign of improvement. Teenie is average weight for her age and height. She walks unassisted with a steady gait. Bert loves to talk. He is largely content with the current situation and recognizes the importance of the care his wife provides to keeping him living in the community with her. Teenie likes to be out among others and balances this with her responsibilities and commitment to her husband. It appears that Bert goes out seldom, more so when family comes to give a hand to get him to the car. They are hopeful that as a couple they will

be more able to spend time with others once they have moved to their new residence. It appears that others will be more readily available for fellowship, living under the same roof and Bert will be more able to get out to the car so they can visit elsewhere. The move itself seems to be an example of their ability to adapt and to balance the needs of each partner to maintain the stability of the couple unit. There is no doubt that Bert could not manage independently on his own in the community. It is also apparent that there is a strong bond between these spouses and their goal is to remain together. They anticipate that this move will assist them in achieving that goal.

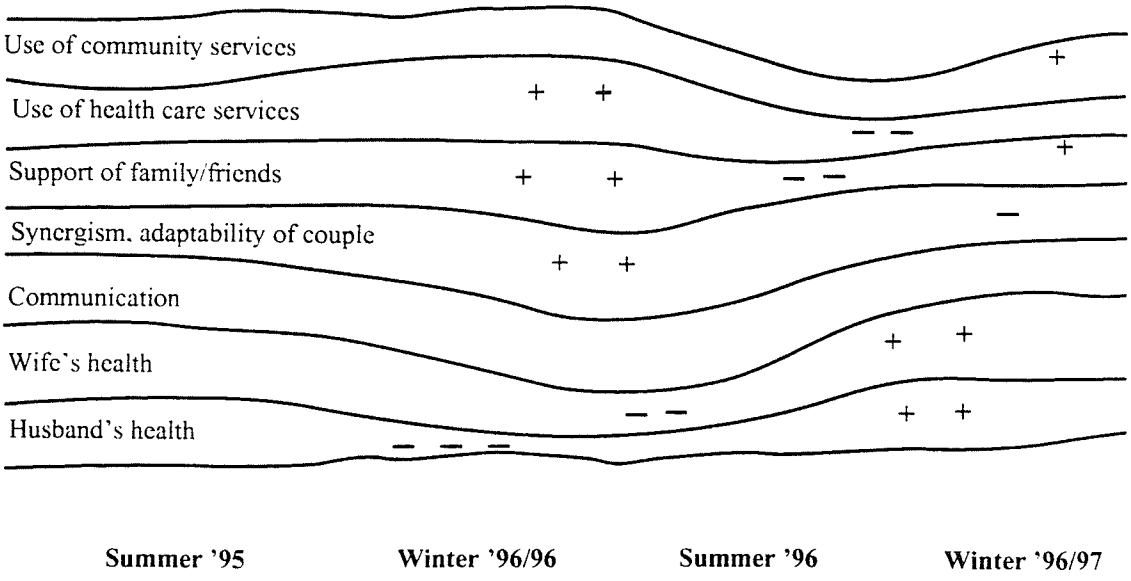
Application of the Model to the Case Study

This couple has maintained their independence and continue living together in the community. The model is applied to illustrate their current living situation. It is difficult to construct the earlier circumstances or to predict the future situation of the couple from the single interview that was conducted. The model, however, is best applied over time to illustrate the changes that the couple has experienced in their living situation. In this instance, caution must be used in the interpretation of the backward and forward projections of the couple from the single interview which does not lend itself to description of their situation over time.

In the summer of 1995, the couple was managing quite well. They experienced substantial help from family and friends and a stable amount of health care services. The husband, Bert's health was quite good, almost comparable to that of his wife Teenie. Into the winter, Bert's health began to deteriorate, and the couple worked hard together to adapt and manage. Their synergy increased in an attempt to cope. However,

Bert's health continued to deteriorate and he found it increasingly difficult to get around. At this time Teenie's health also deteriorated as she developed phlebitis and back problems. As a result, the couple's use of health care services and community services increased, as did the support of family and friends.

Figure 7 Elderly Couple's Independence Model



With the approach of summer, the health of both spouses began to improve, which also resulted in an increase in energy and synergism between them. Their use of community services and health care services decreased and the assistance needed from family also subsided to some degree. As they approach this fall and winter, they will increase their use of community services by moving into the elderly person's housing unit. They anticipate an increased support of friends as they hope to be more mobile and better able to get out of their home. They also hope to spend more time with

friends, living in the same housing unit. There is a projected overall increase in the synergism and adaptability of the couple as they make the move to seniors' housing. A small dip is predicted with the stress of the move, which may be compensated by additional support from family. Generally, the couple believe the move will enhance their ability to manage independently in the community and position them to be better able to cope with the challenges that they will face in the future.

Limitations to using this model in a cross-sectional study are apparent. To ensure accuracy in the application of the model to the living situation of a couple over time, a longitudinal study would be more appropriate. Minimally, an effort to include questions, about the couple's past living situation at specific intervals overtime must be incorporated in order to apply the model somewhat more effectively.

CHAPTER 6 — CONCLUSION

Frail elderly couples, residing in their own homes, in rural communities of 1,500 to 2.500 people, in south western Manitoba, were asked about the resources that they perceived as necessary to maintain their independence and live together in the community. A purposive sample of 19 frail elderly couples known to Continuing Care and Support Services to Seniors programs participated in semi-structured interviews to inform in detail about personal meaning and experience. Initially and for the majority of the session, couples answered questions together. This was followed by some questions that each spouse answered individually.

These couples identified, described and offered comment on three types of resources that were important to them – 1.) community programs and services, 2.) health care services, and 3.) supportive family and friends. They identified issues of concern to them and shared their goals for the future. In addition, the communication processes, patterns and dialogue content were noted. A list of services was created; a model, depicting the factors which contribute to the independence of frail elderly couples, was developed; and a continuum of spousal relationships of elderly couples was generated.

Overall couples were very satisfied with the community services and health care resources that they used. They identified services that decreased the amount of energy that they had to expend or decreased their need for transportation as most useful. They praised programs such as Home Care (Continuing Care), Respite, Adult Day Care and Support Services to Seniors in their ability to address their needs effectively. These

couples reported that family and friends were often the most important resources that they depended upon for support. They appreciated living in smaller rural centres, which they described as 'caring communities' and 'full of good neighbours'. Often when a formal service, such as local transit, did not exist, community organizations and neighbourly supports filled the gap. These couples adapted to having to travel for specialized health services, but felt that a basic core of services should be available in their communities.

Concerns identified by these frail elderly couples focused on the future of Medicare, the current cost of Pharmacare and the unpredictable future cost of other health services, the stability of the Home Care program, the future availability and affordability of seniors' housing and the future existence of seniors' pensions. They worried about what health services would be available in rural communities in the future, in light of the difficulties in attracting and retaining health professionals and the proposed government cutbacks in rural health care funding.

With a foundation of effective and supportive services in place, the importance of the relationship between the spouses and their ability to adapt as a unit became apparent. In some cases it became evident, that while neither partner could have managed on his or her own, as a unit, the couple had developed a role reciprocity that supported them in remaining independent in the community. They jointly negotiated roles and responsibilities assumed by each partner creating a single entity, a couple unit. A continuum emerged with those couples who had developed a mutually supportive reciprocal relationship, at one end and couples, having such difficulty that the existence

of the independent dyad was at risk, at the other end. With a basic foundation of supportive programs and resources in place, the synergism and ability to adapt as a couple unit became apparent.

The main goal of the majority of couples was to continue living together in the community as long as they were able. The 'Elderly Couples Independence Model' was developed which depicts several factors that contributed to the ability of these couples to manage – use of community services, use of health care services, support of family and friends, health of the wife, health of the husband, and synergism/adaptability of the couple as a unit.

The 'Elderly Couples Independence Model' serves to categorize the various factors which contribute to the independence of frail rural elderly couples. An understanding of these factors and an effort to develop programs and resources to address them has great potential to support future efforts of frail rural elderly couples to remain together and independent in the rural community of their choice.

Relevance to Policy and to the Field of Study

Marshall (1993) proposes the development of a Canadian health and aging policy that includes the well elderly, addresses the fit between person and environment, focuses on income security, housing, and other social determinants rather than specifically on health or medical matters, and encourages the active participation of older people in health promoting policy initiatives. He further believes that the creation of policies that take into account the special needs of a less mobile and frail older population, is necessary to provide an environmental fit which facilitates greater

opportunities for independence. This study is an effort to gather information which supports this proposed direction for policy development.

Rural seniors elect to remain in or near the rural community they have known as home (Keating, 1991; Everitt, 1994); seniors prefer the quality of life afforded by living in their own homes (Agbayewa & Michalski, 1984); and elderly spouses favour remaining together as long as they are able (Cantor, 1991). These are priorities that must be addressed in future planning. Understanding the needs and resource use of frail rural elderly couples has important implications for policy development and planning for rural health programs; for the organization of rural community support services; and for adaptation of rural business sector services that are used by elderly residents.

Further, while meeting the needs of spouses as individuals is important, the benefits of providing resources which focus on the needs of the frail rural elderly couple as a single unit are becoming more apparent. Services which address their needs as a couple and provide supports which enhance and stabilize the couple as a unit, have the potential to contribute to the synergism of the couple and to have a positive impact on their ability to continuing to live together independently in the community.

The public and private sectors, including health care and other service providers, can benefit from information that identifies the needs of rural senior couples; sets priorities around the services they find useful; and describes the most appropriate methods for delivering these services. As families of seniors and elderly couples themselves strive to understand how they can contribute to or enhance the ability of couples, as dyadic units, to manage independently, information gathered through this

type of study becomes increasingly important. Assisting elderly couples to remain together and independent in their own homes has the potential to effect the quality of life of senior couples. As well, improving the health and adaptability of elderly couples can, in the longer term, lead to a decrease in their use of health care services and institutions, and reduce financial spending in this sector.

The opinions and input of elderly couples about the programs provided by the Manitoba government that are supportive of seniors, such as Home Care, Support Services to Seniors, Respite and Adult Day Care are also useful for future planning. This study supports the position that these programs and their methods of delivery have shown some degree of success in meeting the needs of rural seniors. This suggests that programs need to be evaluated, such that their strengths can be identified and enhanced, as well as applied to other service endeavours. Understanding the importance of these programs to seniors may have an impact on policy development relative to priorities for future funding of programs.

Gee (1993) suggests that current policy issues for an aging society include the possibility of privatization of current services. She believes that placing the determination of the continuation of these programs with the private sector, may not be in the best interest of the populations served. Research to increase the understanding of the living situations of seniors and their resulting strengths and needs is a necessary foundation to making these decisions most appropriately

The semi-structured interview has been shown in this study to be an effective tool for gathering valuable qualitative data from seniors, which can be used to address

these important research questions. Rubinstein (1994) believes that the use of qualitative methodology is central to understanding aging as a cultural, social, experienced and biological process. Seniors themselves will expand our knowing. The challenge remains for researchers to continue to develop and implement effective research methods that facilitate the collection and analysis of this valuable information from the population of seniors.

By identifying the most useful services and detailing factors that contribute to their independence, seniors provide important information (Rubinstein, 1994). This information will not only assist planners in developing necessary services, but will also have an impact on the quality of life of frail elderly couples and their ability to remain together, in their rural communities, in the years ahead.

Researchers must continue in their efforts to understand the living situations of the elderly and the unique challenges facing elderly couples, if the appropriate resources are to be developed. Research to further explore the concept of synergism and test the proposed model is required to determine their effectiveness in describing elderly couples. The better we are able to describe and understand the frail rural elderly couple the better we are able to plan services, adjust programs, support couples and contribute to the overall success of rural elderly couples in remaining independent in their own homes.

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APPENDIX 1

The Challenge of Coping: Frail Rural Elderly Couples Identify Resources Required to Maintain Their Independence

July 15, 1996

Dear Sir and Madam:

The needs of seniors residing in rural communities are being studied by health care providers, community agencies and the business sector. The reason for this interest is to adapt services and business practices to provide better and more appropriate services and supports to seniors, as they strive to remain living independently in their own homes, in the community of their choice.

Elderly couples are a special group of seniors, who in their later years may have particular needs and preferences that once identified and addressed may support them in their desire to remain living together independently in the community.

Fran Racher is conducting a study "The Challenge of Coping: Frail Rural Elderly Couples Identify Resources Required to Maintain Their Independence". She is interested in talking with senior couples, living in rural communities, to better understand what needs, programs and services they find useful to them as they continue to remain living together, in the community. Those couples that have been experiencing increasing challenges, as changes in their health and mobility occur, are of particular interest, because they are in greatest need of supportive resources and business practices sensitive to their situation.

Fran Racher is a University of Manitoba graduate student, in the Department of Community Health Sciences and her advisor is Dr. Betty Havens. Fran is from rural Manitoba, has many years of experience working with seniors and has a sincere interest in talking to rural couples. She believes that by talking with elderly couples in several rural communities, a better understanding of what resources they feel are necessary to remain living together in their own homes, can be gained.

page 2 letter to participants

She would like to explore questions about health, caregiving, decision making about services and the adequacy of various resources. This information would then be available to those health care providers, community agencies and businesses that would find it useful for planning purposes, in order to better meet the special needs of the growing numbers of rural elderly couples.

Fran would like to come to your home and talk with you and your spouse for about one hour, at a time that is convenient to you. Participation is completely voluntary and your participation will be kept confidential. If you decide not to participate, it will have no effect on your present or future use of community service. If you are interested and willing to participate, please give your name and phone number to the coordinator that has given you this letter, and Fran will contact you by phone to arrange an interview. Thank you very much for your interest and your time.

Should you have any questions, please do not hesitate to contact Fran Racher at (204) 728-4747 at home or (204)729-3453 at work. Should you wish to speak to her advisor, Betty Havens is available by phone at the Department of Community Health Sciences in Winnipeg at (204)789-3427.

Yours truly,

Fran Racher,
Graduate Student, University of Manitoba
Department of Community Health Sciences

Betty Havens,
Professor and Research Fellow
Department of Community Health Sciences

APPENDIX 2

The Challenge of Coping: Frail Rural Elderly Couples Identify Resources Required to Maintain Their Independence

CONSENT FORM

I am interested in participating in a study to identify what senior couples residing in rural communities, identify as resources necessary to remain living together independently in the community. I understand that my name and that of my spouse will be kept confidential as will our personal responses during the interview. Our participation is completely voluntary and we may withdraw or refuse to answer any question that we prefer to avoid. We also understand that participation will not effect any service that we may be using now or in the future.

The interview with me and my spouse will take about one hour of time. In situations where a spouse is unable to participate in the interview, the caregiving spouse will be considered as a proxy.

The interviews will be taped and transcribed to prepare the information for data analysis. However, these tapes and transcripts will be accessed only by the student conducting the research, the student's primary advisor and the transcriber. All data will be destroyed following their use by the student researcher.

I consent to participate in this study, agreeing to and having understood the explanation of the study.

_____ _____

Signature, first spouse Date

_____ _____

Signature, second spouse Date

_____ _____

Signature, researcher Date

APPENDIX 3

INTERVIEW GUIDE

[This guide is a suggested format, to be used with consistency when appropriate. However, this study is using a qualitative approach that relies on the premise of adjustment and flexibility in data collection based on the information gathered. Therefore, some adaptation of the interview format is anticipated and appropriate.]

I would like to talk to the two of you together to gather the majority of the information about life in a rural community as a couple, during your senior years. I would also like to finish off the interview, talking to each of you separately, to get your individual input to some of the questions. Your responses are completely voluntary and you may withdraw or refuse to answer any question that you chose to avoid. Could we start by talking about how long you and your spouse have been married...

1. How long have you and your spouse been married to each other?

2a. How long have you and your spouse lived in this town? In this household? Note type of household? [If not apparent ask...]

2b. Where did you and your spouse live prior to moving here? [Probe for previous residence.]

3. What are each of your roles in your marriage and around the house? [Note role of husband, wife, who is primary caregiver.]

4. When you need the support of others, who are the people that you count on for help? [pause] [May need to add...I am referring to help from family, friends or neighbours.] [List supporters, ask what help each support person provides.]

5. If you need to go beyond supportive individuals, where do you go for help? What health care services do you use in this community that you feel help you as a couple to continue your lives together in your own home? [List...] [It may be appropriate here to develop a list and enquire about each later, or to delve into question 6 and 7 as each support or service is identified.]

6. How would you describe ... these services [each from list above]? [Review each service in terms of]... Does it meet your needs? Why, or why not? Which of these services are the most important to you and your spouse?

7. What has happened in your lives that has led you to decide to use ... these services... according to list. [Ask this question for as many services as are identified, keeping in mind that the same answer may apply for more than one service.]

8. What other services, excluding health services, do you use in this community, that you believe support you and your spouse in living here? [List..] [Use process as #5, #7.]

9. How would you describe ... these services (again review each listed)? Does it meet your needs? Why, or why not? Again which services are most important to you?

10. Are there programs or services that are difficult to use or access? What is the difficulty?

11. Are there factors that make some services easier to use or access? What are those factors?

12. Are there resources that you need or would like to be able to use, that are not available? What would these resources be?

13. Do you have suggestions for improving existing resources or developing new resources?

14. Is there anything else that you would like to say?

This portion of the guide is to be used with each spouse separately.

Name _____ Date _____

1. Is there anything you would like to add to the previous discussion, that you may not have had a chance to say?

2a. How would you describe your health?

2b. How would you rate your health?
Excellent, very good, good, fair, poor

It may become readily apparent as to which spouse is the caregiver and questions should be altered accordingly, to be sensible and appropriate. However, even those receiving care often provide support to others and effort should be made to elicit this type of information.

3. Are you able to get out of the house?
Yes or no. [Offered detail should be noted.]

4. Are there personal care things that you are not able to do for yourself?
Yes or no. [Again if answer is yes, seek detail and note.]

5. Are there things around the house that you need help with?
Yes or no. [If yes, seek detail.]

6. Does your spouse help you with personal care or household chores?
   What type of help does he/she provide?

7. How would you rate the health of your spouse?
   Excellent, very good, good, fair, poor

8. Is your spouse able to get out of the house?
   Yes or no. [Offered detail should be noted.]

9. Are there personal care things that your spouse is not able to do for him/herself?
   Yes or no. [Again if answer is yes, seek detail and note.]

10. Are there things around the house that your spouse needs help with?
    Yes or no. [If yes, seek detail.]

11. Do you help your spouse with personal care or household chores?
    What type of help do you provide?

12. How many times in the last six months have you required the services of a physician? Has your spouse?

13. How many times have you used .... other health care services as identified as used in Part 1. Explore what activities these services have provided.

14. How would you describe your satisfaction with life in general at present?
    Excellent, good, fair, poor, bad

15. What is your goal for the future, in terms of continuing to live with your spouse in the community?

16. What resources or supports do you believe are most important to assist you in attaining that goal?

17. How old were you on your last birthday?

18. How old was your spouse on his/her last birthday?

19. In your opinion, how well did your household income meet your needs over the past year?
    Very well, adequately, with some difficulty, not very well, totally inadequate
    ...[If response is less than 'adequately' ask] What were the difficulties?

20. If you had additional discretionary income, what would you use it for?

[The interviewer will observe the surroundings, the home of the couple being interviewed. Note will be made of the interaction between the partners. Who is responding to which questions? The degree of agreement or disagreement. The apparent roles of each of the partners will be recorded. Any health related states of either individual, including cognition, mobility and use of aides will be noted.]

Thank you for your time and your willingness to share your thoughts with me!