PSYCHOSOCIAL DEVELOPMENT IN INTENSIVE HOME REHABILITATION

Amongst older adults in post-hospital treatment

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In memory of my dear friend, mentor and colleague
Elinor Brunnberg.

And a special thanks to my supervisors Gunnel Östlund
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ABSTRACT

Introduction. According to the Swedish ministry of social affairs, the future care for older adults must have a higher degree of psychosocial wellbeing weaved in to it. It must also be cost effective to smoothen the approaching demographic transition (SOU 2017:21). This study aims to present an understanding of how psychosocial wellbeing can increase amongst older adults after a hospital stay by implementing intensive home rehabilitation (IHR).

Method. In this study a pre-test, post-test design with control group is used to measure the effect of IHR on psychosocial wellbeing amongst older adults. The intervention group received IHR, and the control group ordinary home service. The results of the effect measurement are interpreted thru symbolic interactionism and role theory. Results and analysis. Psychosocial wellbeing did increase for those who received IHR. But not sole due to the intervention. Psychosocial wellbeing in IHR can be achieved in many ways. One of the ways could be to use social workers as social counsellors, as they are in this study. But they can also be used as strategic persons who can ensure a holistic view of the rehabilitation, creating social relations, handling asymmetric power relations and creating favourable conditions for participation.

Key words: older adults, intensive home rehabilitation, reablement, psychosocial wellbeing, social work, multi professional teams.
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1 INTRODUCTION

Beside IKEA, ABBA, and Ace of Base, Sweden is generally known for its well-developed welfare state (Åmark, 2011). The welfare state is to a high degree dependent on strong taxation founds. These taxation founds in turn are dependent on an active labour market, and here lies a paradoxical problem that is becoming increasingly dire. Because of the successful welfare state, the Swedish people live increasingly longer and the population is getting older. This means that a higher degree of citizens will leave the labour market for pension leave which means less taxation founds and less people available to take care of the increasing number of older adult citizens. The phenomenon is called the demographic transition and is not an exclusive Swedish problem as many western and industrial countries face the same challenge (Government offices of Sweden, 2008).

To battle the challenges of an ageing population, many innovative solutions have been presented. A prolonged work life and robots taking over parts of the labour market is just two examples (Ekholm, 2010). The Swedish ministry of social affairs has appointed that it is desirable to postpone age related illnesses amongst older citizens to as late in life as possible, both from an economic perspective and a humanistic. Such delay of illness is another suggestion to battle the demographic transition. The key to living a healthy life longer lies not only in the possession of a functional body, but also in a healthy mind (SOU, 2017:21). To achieve such delay, Eskilstuna municipality have launched a project called Intensive Home Rehabilitation (IHR). IHR aims to achieve reablement of older persons who have been hospitalised for any reason by coordinating intensive treatments from multiple professions who works with a person for a shorter period of time in their own home. This is supposed to bring back both lost bodily functions and psychosocial wellbeing. To reable a person’s psychosocial functions means to bring back lost social dimensions that promotes a person’s psychological wellbeing, for example by preventing loss of social contexts or building new roles that advocates an individual’s social status from the stigma of old age. Eskilstuna municipality has recruited social workers to assess and mend psychosocial distress amongst the older adults. However, it is not clear how psychosocial wellbeing best can be promoted within an IHR environment.

1.1 Aim and research questions

The aim of this study is to present an understanding of how psychosocial wellbeing can increase amongst older adults after a hospital stay by implementing IHR.

To reach the aim, the study begins with a validation analysis of a new instrument to measure psychosocial wellbeing called General population - Clinical outcomes in routine evaluation (GP-CORE). The instrument is then used to measure the effect of IHR on psychosocial
wellbeing. Finally, analytical claims are made concerning how IHR can further increase psychosocial wellbeing amongst older adults.

**Research question I:** How can GP-CORE be used as a measurement of psychosocial wellbeing?

**Research question II:** In what way does IHR affect the psychosocial wellbeing of older adults?

**Research question III:** How can psychosocial wellbeing be increased amongst older adults by administrating IHR?

### 1.2 Key concepts

#### 1.2.1 Reablement

Reablement is the aim of IHR treatment and means to regain functions that have been lost. The concept of reablement is broad and differs slightly depending on what organisation is claiming to administer reablement. Originally, reablement emerged as a term within the realm of social welfare alongside home services. However, the concept has gradually shifted into the therapeutic/rehabilitating area (National Audit for intermediate care, 2014; 2015).

The borough of Royal Greenwich (2016) defines reablement as the concept of a process to restore a person’s abilities that has been lost due to old age in combination with hospitalisation. It is a process of rehabilitation that requires professional support from many different fields of expertise like occupational therapists, physiotherapists, nurses etc. There isn’t really a limit for what professions can be used; it depends on the need of the individual. Aside from increasing older people’s independence from municipal aid services, reablement is also considered to be one of the British councils (municipalities) most important tools of cost management of the ageing population (communitycare.co.uk, 2017).

Characterising features of reablment is that it is given under a shorter period of time (around 6 weeks). During the period, the treatment is intensive and often wearing on the individual. Goal setting and goal communication is also considered a key feature to motivate all involved to precede the process. The final goal is to regain lost abilities and thus gain independence from caring services that is otherwise often deployed after a hospital stay (Whitehead, Walker, Parry, Latif, McGeorge, Drummond, 2016).

In this study the concept of reablement is manly used to describe the empirical observations and as an understanding of what IHR is. Mind that psychosocial wellbeing is what is measured in this study. Hence, other parts of reablement are not present in this study.
1.2.2 Psychosocial wellbeing /illness

The concept of psychosocial wellbeing /illness can theoretically be defined as partly the belief that social and psychological factors co-operate to effect human suffering. And partly that therapeutic problem-solving method should consider both psychological and social aspects of an individual’s problem, working with both parallel (Lenneer-Axelsson and Thylefors, 1987).

A psychosocial view is a stance often used in the realm of work life studies and social work to emphasise an individual experience of acting in relation to her/his environment and social surroundings. When using the psychosocial view in relation to health or illness it is usually involved in describing causal relations to social events in the working environment (mind that causal here is more casually and unscientific used then the methodological meaning of causal), events that lies beyond the technical and medical realms, and closer to the social and psychological (Karlsson, 2004).

According to the World Psychiatric Association, psychosocial rehabilitation is the process of implementing interventions to help an individual develop their emotional, intellectual and social abilities, along with creating conditions that allows the person to live, learn and work in the community that s/he belongs to (Rössler, 2006).

One way of approaching psychosocial wellbeing from a scientific point of view is to use the psychosocial variables suggested by Palacios, Torres & Mena (2009). These variables concern the older adults living situation, mutual dependency on others, subjective health, healthcare contacts, feeling one’s age, community participation, physical activity.

The term psychosocial wellbeing /illness as it is described above is central in this study. Partly to validate the instrument GP-CORE for its ability to tap the change in wellbeing of the participants, and partly for analysing the results of how the IHR intervention affected the participants.

2 PREVIOUS RESEARCH

Because it is unknown if and how reablement has an effect on psychosocial wellbeing, the research review is mainly concerned with experiences from other reablement bringing interventions and what is considered successful approaches in relation to the Swedish environment.

The main findings from the research review is that Sweden already have a similar informal attitude towards what care is good and what aim the care process should carry as that which is emphasised within a reablement process. Also, most research to date is concerned with the healthcare part of reablement. In fact, social support and social work is hardly mentioned at all in the body of literature. This is unfortunate because when non-traditional healthcare
professions are used in the reablement process, evaluations show increased effect of the intervention.

2.1 A new field of caring for older adults- does reablement have a place in Sweden?

Reablement starts to appear in research articles as a concept around the beginning of 21’st century. Thus, the concept is relatively new which may reflect the absence of the concept outside the United Kingdom and Australia. In Sweden, the concept is merely beginning to establish a foothold, which have led to reflections about the underlying philosophy and how it corresponds to that of the traditional ways of conducting care services. There is a disjunction in the English care system between the intermediate care facilities and the long-term care system. The reablement process has a natural place somewhere in between the two with implementation directly when the need arises and extending into the long-term welfare services. Glendinning, Clarke, Hare, Maddison, and Newbronner (2008) has described how these two types of British care differ in terms of how out-come goals is defined and used in the daily care. In the intermediate care, the outcome goals are clearly described and communicated to the persons of interest. But in the long-term care system they are not followed thru and are actually described as non-existent. This causes problem for the reablement process, as setting and working with clear goals is an important feature of the process. The findings of Glending et. al (2008) is relevant for implementation in a Swedish context mainly because Sweden have similar problems. In Sweden, the problem of several actors working in different ways with the same issue has popularly been known as the downpipes-organisati. organisations that work towards the same goal and with the same persons but don’t communicate nor coordinate their work, sometimes even work against each other (Gustavsson, Barajas and Ekberg, 2007; Alexandersson and Jess, 2015). Thus, the need of coordination and common goals between different realms of the welfare system is relevant also in a Swedish context.

In Sweden, there are currently two dominant ways of understanding how care of the older adults is best conducted. The first one, that is also the oldest and informal, are the concept of help-to-self-help. The concept has been around since the 80’s and basically means that a helper should help the caretaker so that the caretaker can help herself, not so different from empowerment. The concept is old and very well rooted in the very essence of the workforce of caregiver’s. However, it could be considered informal as it is not mention in any legislation but merely as municipal guidelines. Help-to-self-help has touching points to reablement as they both aims to making the individual as independent as possible. But they are also fundamentally different as reablement is more focused on a professional stance by including the necessary expertise for causing a long-term effect, while help-to-self-help is more focused on the here-and-now situation, helping people without violation of integrity. The second dominating way of understanding Swedish care for older adults is New public management (NPM), which has recently taken over all areas of the public sector. These two sets the stage for the introduction of IHR and reablement to the Swedish care system. There have been theoretical discussions of whether they can co-exist as hep-to-self-help (and also reablement)
is different from plain service interventions. A service intervention is something nice, short term that according to the logics of a market would be appealing to a customer, while help-to-self-help and reablement means a short term effort which is less appealing to a customer. This is yet to be supported by empirical evidence (Dahl, Eskelinen, and Boll Hansen, 2015).

However, it is clear that the mindset of the Swedish care workforce is already very much focused on that care of older adults should be focused on achieving independence and dignity amongst the care takers which also is the fundament of reablement and IHR. Thus the chances for successful implementation in a Swedish setting are good.

2.2 The main effects of reablement

The purpose of reablement is to help older individuals to live their life as independent possible, by helping them regain skills that may have been lost due to i.e. hospitalisation or fall injuries. When the concept of reablement first started to appear across welfare organisations, it was tested and used on those individuals who were assessed to be amenable for the service. This yielded good results, which led to a more extensive use in the United Kingdom. The extensive use of reablement included individuals who were less amenable then those in the beginning. This caused the results to become more moderate. From these results Rabiee and Glendinnin (2011) draws the conclusion that the effectiveness of reablement is strongly effected by whom it is offered to. The more amenable an individual is, the better the results of reablement seem to be. Thus it is motivated to talk about a threshold as to when reablement is no longer motivated seen from both an economic perspective but also from a human suffering perspective as reablement is a tough process to go thru for the individual.

As the concept is relatively new it is still unexplored in many areas, especially from a research point of view. In 2015, Witehead, Worthington, Perry, Walker, and Drummond conducted a research review over what interventions reduces dependencies in personal activities amongst persons who uses home care services. 13 studies and almost 5000 individuals were included in the review. The quality of the different studies varied greatly and many were evaluated as having a great risk of bias. The findings were a disappointment and only offered limited evidence that interventions targeted at personal activities of daily living can reduce the home care dependency. There are however more recent studies, like that of Lewin, Concanen and Youens, (2016) that show a statistical significant reduction of such services after gone thru a reablement programme. With this I, the author, wish to state that the research field is young and there is still a lot to uncover which is why one should be careful to draw to extensive conclusions on the different research results presented in this study and elsewhere.

2.3 Professional composition in reablement teams

A corner stone within IHR and reablement is to bring in the needed expertise that can give their view on how to help a person regain his/her abilities. For example, nurses, occupational therapists, doctors, social workers etc. But the foundation of the teams is the service worker,
The role of the service worker has been twitched and tweaked back and forth to find a good match towards the versified needs of the individuals and the reablement process. It is however, in the UK as in Sweden, a problem that they often have a diverse background with no formalised knowledge or profession. Thus it is hard to say something general about what role is best for them within a welfare organisation (Nancarrow, Shuttleworth, Toune & Brown, 2005; Swedish ministry of social affairs, 2017). The role of the service worker is important as they are treading on the area of social work. It should be noted that the service workers are complementing the social work in very important ways, as they are the ones who offer the physical closeness and have the best chances of building a relation with the individual. Or, at least that can be assumed as the support workers do a wider range of tasks.

Management is another important issue for the reablement process. It is usual in Australia that healthcare professionals are appointed managers for the multi professional reablement teams. Multi professional competence is a key feature in the reablement process/service. The concept of multiprofessionalism extends beyond the typical healthcare professionals. For example, it has been evaluated very successful to include occupational therapists in the reablement process (Whitehead et.al, 2016). Research has shown that having non-healthcare professionals in managing position thru out a reablement process actually increases efficiency at the outcome measures activities of daily living, instrumental activities of daily living, assessment of quality of life instrument, modified of falls efficiency scale, and timed up and go (Lewin, Concanen and Youens, 2016). Across these five measurements the assessment of quality of life is especially interesting for the subject of this study. Lewin, Concanen and Youens doesn’t speculate in what the reason behind this finding may be, but states that there are many unknown factors to what makes reablement services successful. With their results it seems that the executive staff and managers don’t need to be the healthcare professionals themselves, it could be the service workers with support from the multidisciplinary professional teams in the background. The service workers in the study had received special training from these health care professionals and support thru out the reablement process. The presence of social workers is not mentioned in the evaluation of Lewin, Concanen and Youens (2016). The authors proclaim methodological problems behind their study and do not want to generalize their results in anyway. But the information is still of value as so little is known behind the working mechanisms of reablement. In this case, something is better than nothing.

2.4 A holistic view of caring for older adults

As mentioned above, it is easy to fall in the trap of believing that reablement is a healthcare process which limits the professionals scope of action. It is clear that reablement is a holistic process that requires knowledge from a vast number of fields beyond the ordinary healthcare field. For example, one deciding factor of success is the right use of technical aid tools, seen as a spectrum from the ordinary aid to the modern high-tech tool for communication, GPS-tracking etc. (Rabiee and Glendinnin, 2011). Another important area is of course the psychosocial wellbeing of the individual. Having someone to talk to, share ideas with and
disengage from stressors together with is generally seen as important features of psychosocial wellbeing. Family and friends are often used as such a resource, not only in a reablement or caring process but for all people. In reablement, which is an intermediate form of care, many of the interventions are performed in the own home of the individual. Because of this, it is inevitable not to include friends and family in this process because they will occupy themselves at the location whether the caregivers want to or not. It is however not a bad thing, quite the opposite actually from a psychosocial point of view, and their presence can and should be harvested to help the caretaker (Wilde and Glendinning, 2012).

Hjelle, Alvsag & Forland (2016) has interviewed friends and family of people who is going thru a reablement process and found five critical bullet points in common that are requested from them that can enhance their ability to be supportive. (1) To give and receive information and to be involved. Many people report to be excluded from the process and will because of it have a hard time to explain and motivate to their close one why a reablement process is important and beneficial. (2) To be treated as a resource in the work with the individual. Much like the steep-slope organizations, mentioned above, that causes welfare organisation to counteract each other and do double work, this organizational wall is also described by the friends and family who is kept out in the cold. Still, they feel that they are expected by the caregivers to participate in the reablement process. Expectations that is unrealistic in relation to their capacity (time they have to spend on their friend or relative and knowledge). (3) Conflicting expectations. It is not only the expectations from the caregivers that are unrealistic, but also the expectations from the older adult him/herself. The presences of professionals are appreciated from friends and family as they usually have been performing informal care for a long time, which now gets slightly relieved. (4) Increased time for themselves. (5) Follow up programs. The lack of follow-up programs is highlighted. Friends and family are those who are there before the reablement process and are the ones that will be there after the process. They are the ones who can see the outcomes from an outside perspective. But such observations are not used for assessment of whether further interventions are needed etc.

Such follow-up programme goes hand-in-hand with setting clear goals and how to achieve those goals. The goals need to be clear for all involved in the process. It has however been shown that goal formulation and communication have room for improvements in the English care settings. For example, it is common that the goals are formulated by a manager and communicated to the service workers and the caretaker once. But a person who is in pain or has other conditions that effect the ability to concentrate needs to receive this information repetitively. Not just to remember it, but also to motivate themselves to stick to the program. This is a pedagogical issue, people absorb information in different ways which mean the caregivers need to tailor the communication plan to the needs of the caretaker (Glendinning, Clarke, Hare, Maddison, and Newbronner, 2008; Hjelle, Alvsag and Forland, 2016).
2.5 Conclusions

It is clear that reablement among older adults are seen as a potential utility for increased independence that is cost efficient, both from an economic, - and human suffering perspective. It is however important to note that the field is much broader than simply healthcare. Healthcare is an important part of reablement, people need the right medication and they need doctor’s consultation on their bodily functions. But it is also a matter of social health, of tailored aid solutions and of informal support. This further marks the importance of describing non-traditional healthcare professions (like social workers) role in the reablement process.

It was mentioned earlier that most of the research in the field of reablement has been conducted in either England or Australia. This creates generalization problems as the welfare states are built differently seen to legislation, cultural influences and decommodification (Esping-Andersen, 1990). For example, it is possible that the described effects from reablement in one setting are already saturated in a Swedish environment or vice versa. Also, the different concepts in the research above create confusions. The most obvious examples are the concept of service worker, care manager and health care professional mentioned by Lewin Concanen & Youens (2016). Without knowing exactly what the authors mean with these concepts it is hard to draw any conclusions on how their result would be translated into a Swedish setting.

There is also a striking absence of social work in the research that has been found. Social work, social workers, and psychosocial wellbeing in general are not mentioned other than indirectly. Even thou the importance of multiprofessionalism are stressed across different articles.

3 THEORETICAL FRAMEWORK

The theoretical framework of this study departs from the basic ontological and epistemological assumptions of critical realism that pave the way for moving on to the way psychosocial wellbeing is developed at older ages. The two main theories, apart from the philosophical assumptions, are symbolic interactionism and role theory. The two theories are used because of two main reasons: (1) they both align with the IHR ground principle of reablement (regained abilities is the way to healthy ageing instead of accepting older age as a new development phase), (2) they both focus on social consensus and social roles as the way to psychological wellbeing, or in other words: psychosocial wellbeing.
3.1 Basic philosophical assumptions

The author of this study accepts the philosophical idea of critical realism, presented by Roy Bhaskar (2014). Bhaskar uses a positivistic ontological base, but emphasises that the objective reality in its crude form is unreachable for the human intellect. To understand the nature of things, observations must always be analysed and interpreted. If not by the researcher, then by the reader.

Critical realism has been a controversial philosophy because it doesn’t specifically advocate positivistic or hermeneutic knowledge, but attempts to combine them in one and the same paradigm (Benton and Craib, 2011).

3.1.1 Ontological assumptions

Reality do exists outside the perception/interpretation of human intellect. The critical realism perspective can be applied on both the natural science and the social science. According to Bhaskar (2014), both natural and social science is influenced by law-like structures. The objective nature of these structures however cannot be accessed directly by human intellect because the human intellect is always biased. When presented a set of objective measurements from a research study, the receptor will always interpret the results based on personal bias. Hence, it is scientific favourable if the researcher assists the reader to interpret the results in a structured manner.

Within the realm of social science, reality is made of structures and actors. The actors are the individuals whose collective understanding of reality creates structures. To understand social reality, one needs to pendulum between these micro and macro levels. A democratic system makes a good example. In a democratic country, actors who submit to the democratic system cast their votes on election day and follows the laws made by the representatives of the majority. Hence, the actors are directly influenced by a democratic structure, but the actor also has the ability to modify the structure. The actor can rebel against the structure by for example disobeying the laws, threaten politicians, use violence etc. Bhaskar (2014) says an agent can reproduce a structure or transform the structures. If one accepts that structures have a law-like influence on humans, then it becomes meaningful to study that from a quantitative stance (Benton and Craib, 2011).

In this study, the anticipated effect of IHR is perceived as that of a structure which affects individual actors, and that can be observed at an aggregated level.

3.1.2 Epistemological assumptions

The basic epistemological assumption when applying the ontological view of Bahskar (2014) is that the structured phenomena should be observed and understood abductively. Meaning, conclusions is drawn based on empirical observation and theoretical frames weaved together to describe the conditions of the finding and to find the best fitting explanation for the observation. Description of reality is achieved by using transcendental arguments. A transcendental argument is the basic assumption that must be true for an empirical
observation to be true. To use the democracy example again, if one observation reviles that a person is refusing to participate in the general elections, some transcendental arguments would be that (1) there exists a democratic system, (2) the actor is able to choose whether or not to participate, (3) the actor has at least one vote, etc.

As stated above, reality can be observed but never understood unbiased and that is why the researcher should, according to Bhaskar, interpret the results for the reader. Not only due to the bias issue, but also to make the actor perspective understandable. The actor and the structure must always be understood in a symbiosis, or as multiple layers of reality (Bahskar, 2014; Benton and Craib, 2011).

### 3.2 Activity theory

The theoretical field that embraces the social parts of human ageing can metaphorically be described as two trees. Each tree is growing branches of sub-theories that generally has the same basic assumptions of human development and needs as the tree trunk. The two trees are however fundamentally dichotomous to each other in their basic explanation of human development at older days. The first tree is generally known as the activity theory. The activity theory basically identifies ageing as a process of losses. For example, the loss of bodily function/s, memories, friends and family etc. To make up for these losses the older person needs to be activated. To do things s/he likes, to discover and rediscover sides of one self that emerge in social relations with others and so on. This theoretical tree consists of several branches (or sub-theories if you will), which will be described below. The other theoretical tree is that what is called the disengagement theory. As mentioned it is fundamentally dichotomous from the activity tree as it explains the development of older individuals as a genetically guided process of disengaging the individual from her/his social bounds and from society. A way of preparing to leave the world of the living by gradually disengaging. This perspective may seem dull and depressing but is actually rather enjoyable for the older individual as perspectives change and other things become more interesting than the previous occupations. Some argues that the disengagement tree is viable and legit because the process can be seen across the whole world, but with some twists in different cultures. Generally when people grow old, other things become more interesting to them and society starts to prepare for the final disengagement: death (Tornstam, 2010).

It is not hard to see how IHR rather corresponds to the activity tree than the disengagement one. IHR aims as explained earlier to cause reablement. To give back the abilities to people that they have lost during their walk across life. And by doing so, postpone various kinds of suffering. Thus, activity theory is what will be used for interpretation of the findings in this study.

The research questions have a high degree of association with what happens between people. What happens with people when we interact with each other and what kind of influence that interaction have on people’s health. But, healthcare professionals dominate the context in which this analysis is applied, thus one must also include the somatic dimension of human suffering. We have now arrived a bio-psycho-social explanation to human suffering. Because
health can never be disengaged from neither biological factors, nor psychological or social factors, the three are welded together and all parts affect each other (Karlsson, 2004).

In this study psychological health/illness is manifested by two of the branches from the activity tree, which will be used to make a theoretical framework. The first one, symbolic interactionism, offers a way to understand how a person can make sense of who s/he is in relation to symbols around the person. The other branch is role theory that departs from where symbolic interaction ends. Role theory analyses a person’s becoming in relation to others, often used to analyses gender roles, team work and cultural roles. In this study it will be applied to the process of becoming in relation to the IHR treatment and how it effects the person.

These two branches of the activity tree provide a reasonable explanation model for whether the social interaction is beneficial in post-hospital care of older adults.

3.3 Symbolic interactionism

Symbolic interactionism is the theory of how we humans react and respond to social symbols around us. A social symbol can be anything in our surroundings, a rock, a house, a person or a situation. We are looking for symbols that is familiar to us because if they are familiar we have an established protocol of how to use them. This way, we don’t need to learn how to handle every object or situation over and over again. The theory is generally seen as a product of George Herbert Meads work. Mead (1910) departs from the process that steers all animals (including humans) physical movements. The vascular expands when activity occurs; chemical changes in the brain to make limbs move or creates the pain that arises when some body part malfunctions. Processes like these are where the symbolic interactionist view takes its departure. According to mead, we mammals need to understand all the sensations that are associated with the processes that was just described. We give them meaning. As a trivial example, pain generally means bad, and arousal means good. Taken a step further, the arousal can be triggered if the mammal is exposed to challenge, like jumping over a ditch. If the challenge is overcome, the reward will be the arousal which was given the meaning good. Thus, jumping a ditch will also mean good. This is a way of giving the world meaning and it is essential to understand symbolic interactionism.

There are two ways according to Mead (1922) that we make meaning of reality. The first is that of the objective world, how we understand objects thru sensations. For example, jackets as a group of objects, we recognise their shape and sizes and understand that it is a jacket. The meaning most of us associate with a jacket is warmth and fashionably expression. How we make meaning of objects are fundamentally different from how we make meaning of subjects. The same principals of meaning-making still apply to subjects as it does to objects but with one important, and complex, addition: with subjectivity comes insight of how our attitude towards the other subject effects the relation between us two, and thus also affect my meaning making of the other person.
The process of identifying and interpreting objects, people and situations are constantly ongoing and is happening simultaneously in all people. This is important to understand when we move on into what Mead (1932) calls the social act. When people meet and socialise two things happen. Well, of course thousands of things happen, but two things that is of concern for the symbolic interaction analysis. First, all involved persons identify the social act in which s/he is about to engage. Second, they identify and interpret the others act to form a social act. This is a way to handle our social relations, we humans need to understand the different acts that is expected of us in different situations. For example, we are expected to behave differently during a debate then during a wedding ceremony, or a war.

Symbols becomes significant symbols when consensus arises about their nature (Mead, 1922). A common maker for such symbols are language, including non-verbal language like gestures and body language. The self (which is present in all human beings) is, according to Mead (1938) our reflexive ability that is capable to express itself in language on a meta level. This ability is used to position a person towards significant symbols. For example, by position oneself as a person that can operate a car better than most others. Or as unfit to climb a mountain. When the self-interprets significant symbols there can be significant others or generalizing other. The generalizing other is used by our self to understand who we are in relation to how others understand us. A senior citizen may be treated in a special way because the generalized group are seen as they should be handled by younger citizens in a special way. Maybe as they should be cared for, like a special kind of music, be sweet etc. this way of making meaning of groups of people contributes to how those people understands themselves and their role in society. The same mechanisms are at work when interacting with the significant others but on a more micro level. A person understands who s/he is by understanding his/her role in relation to a person that is near to them. In the field of older adults such a person can be a spouse, a child or a care taker. This perspective is important in this study because the IHR are expected to increase psychological wellbeing when the older person has many experts’ professionals around her/him. Here lie many theoretical paths which such a situation may lead to. The caring perspective would according to the symbolic interaction theory categorize the care taker as a patient which in turn would contribute to a changed view of who the person is, a person whose ability to survive is dependent on the goodness of others. Or, can the IHR team work in such way that the person takes on a more active role in the IHR process? a role where the person’s participation is an asset to the IHR process. Surely such a position would benefit the self of the person’s ability to understand him/herself as a valuable resource and thus generate wellbeing.

To further explore the importance of roles in a process with others, we will venture into the role theory.

3.4 Role theory

Role theory is generally seen as a continuation of Meads symbolic interactionism, but it differs as it is more focused on micro relations and how they effect a person’s understanding of her/himself. Within the role theory people’s behaviour is explained by their roles. Just like
in the theatre we behave like we are expected to according to the role that we play. One of the most commonly cited thinkers in the field of role theory is Erving Goffman. Goffman (1959) used the theatre as a metaphor for how people contribute to the great play of social life and to explain why we behave as we do towards one and other. He actually didn’t call his work role theory, but dramaturgy to emphasize the similarities between our social lives and a theatre stage. The theory is large and only vital parts of it will be used in this study. Role theory as it is used in this study uses the dramaturgy of Goffman as a base, but also ideas of other thinkers to better aim the theory towards the psychosocial wellbeing amongst senior citizens.

We people play several roles at the same time, for example a person can play one role as a parent, one role as a colleague, one as a partner etc. We enter different roles in different situations. Roles can offer some security, just like with the symbolic interactionism we recognize situations as symbols, which we have a protocol of how to handle. The role we play in different contexts are based on that protocol. Roles are both brought upon us by others and chosen by ourselves, and not seldom do we chose in accordance to what other expects of us, a simple way of gaining the groups approval and avoid stigmatisation (Goffman, 1963).

Throughout life we gain, evolve and change roles. For example, a 10-year-old play a different role in relation to a parent than an adolescence play in relation to a classmate. The same principle can be applied to the different phases in life. There are generally nine levels in life where a person is expected evolve and shift roles. The levels are: (1) toddler, (2) school-age, (3) adolescence, (4) younger adulthood, (5) parenthood, (6) middle-age, (7) age of grandparenity, (8) healthy pension age, (9) fourth age, also known as the older elderly. Up to about level 6 or 7, a role shift is generally associated with more responsibility in relation to society, but the rewards and status is also greater. After that the status, responsibility and rewards declines and at the fourth age many report feeling stigmatized and unwanted. This is of course highly interesting in relation to the IHR treatment and how it can increase psychological wellbeing. One theoretical explanation for this decrease of psychological wellbeing is the reduction of numbers of roles a person is encouraged to take on. Tornstam (2010) claims that the number of roles increases with each level until the pension age. At this point in a person’s life the person is expected to take on a reduced number of roles, indirectly telling the person s/he is not capable to handle any more advanced roles with increased status. Alongside of the losses of roles a person is expected to handle, social losses are also occurring. Even if the person him/her self is healthy and active, it is common and unavoidable that significant others (from the symbolic interactionism) sooner or later starts to decrease their health status and die. Theoretically, the older person now has lost some of his/her prestigious roles from previous levels, significant others who still encouraged the person to maintain some of the more prestigious roles. Beside the sorrow in loosing someone we love, we also lose parts of our self when those that help us understand who we are dies away from us.

From this angle, the success or failure of IHR to increase psychosocial wellbeing may be mistaken for the grief that comes with role confusion, the normal grief and psychological stress that comes with loosing loved ones or the struggle to accept a new role as dependent on others to survive. A person who is being cared for, and is used to be cared for would according to the theory take on such a role. Starts playing along with being on the receiving
end of the care situation. Starting to act in relation to the most beneficial outcome for the person in this situation etc. The IHR care-team would need competence to battle this condition. To make sure the care taker is not pushed in to dependency. The role of dependency would be the opposite of reablement which aims to ableing a person to keep on living his/her life without opposing influence of others.

3.5 Conclusion

The theoretical framing of this study starts with critical realism. Critical realism is an ontological view of reality that accepts an objective reality that is not accessible without a biased analysis. This applies on both natural and social science. In social science, like this study, the objective reality is understood as social structures that both affect the individual actors, and gets reproduced or transformed by the same actors. Hence, it makes sense to study the objective reality with instruments, and make analytical claims on how the symbiosis between macro and micro phenomenon co-create social reality (Bhaskar, 2014).

This study uses the symbolic interactionism theory and role theory, both corresponding to the activity theory of ageing which in turn corresponds to the basic understanding of reablement: to reclaim what has been lost is the way to good ageing. This means that ageing is seen as a process of losses that causes misery until death occurs. To mend the misery, interventions can be made to slow down the losses, like exercising to prevent loss of strength, solving sudoku to prevent loss of memory, or advocate social roles to prevent psychosocial stress.

The theory of symbolic interactionism is used to analyse what happens when older adults interact with symbols that are known to them, but also the inter-relational understanding of symbols. A symbol can be anything from an object to a feeling or a situation. Hence, the theory will be a key to understanding how older adults can cope with the social situation of undergoing an IHR process. And how such situation affects their psychosocial wellbeing.

The role theory further emphasises the social relations effect on humans psychological wellbeing by analysing the becoming of a person in relation to his/her social relations. As this study is an effect study, conclusions will mainly be drawn by applying the theoretical perspectives on the empirical observations, together with what is known about the intervention thru the research review.

4 METHOD

In alignment with the critical realism explained in the previous chapter, this study uses partly a quantitative approach to measure how IHR effects psychosocial wellbeing on older adults at
a structural level, and partly an interpretative approach to understand how IHR can improve psychosocial wellbeing at a actors level.

### 4.1 Design

This study uses empirical data from two different questioners: GP-CORE and demographic background questions. The questionnaires are described in detail in section 4.2. The data has been gathered at two time points. The first time point is before the IHR intervention and the second after it. A so-called pretest-posttest control group design. A pretest-posttest design is usually referred to as an experimental design (Creswell, 2014).

The intervention group consists of Swedish older adults who receive IHR treatment and the control group contains Swedish older adults who receive ordinary home care services offered by the municipal assessment officers.

The participants were first identified by an inclusion criteria screening. After the identification the participants were asked if they wanted to participate in the IHR research project. Those who accepted were randomized into the intervention group or the control group.

![Figure 1. Illustration of the overall design. O1= first observation, X = intervention, O2 = second observation.](image)

### 4.1.1 Intervention

The intervention is the intensive home rehabilitation (IHR). IHR aims at re-abeling a person so that s/he will be more independent from other municipal aid instances to live their lives. This is done by concentrating efforts of several professions and one of those are social workers, whose role it is to specifically bring psychosocial wellness to the older adult. In the Eskilstuna IHR project, social workers have mainly filled the role of social counsellors in the intervention group. A social counsellor is a person who is responsible to fulfil the need of having a dialog/conversation. The amount of dialog given to each person was adjusted to the assessed need. Social workers in the role of assessment officer were also present in both the intervention group and control group.
It should be mentioned that the counsellor that was originally hired left the project after some time and difficulties arose to find a new one. This resulted in a shorter period of time with no counsellors at all tied to the IHR project.

4.2 Participants

The inclusion criteria for participation in this study was that the participant needs to be above sixty-five years of age and that they are applying for municipal services. Exclusion criteria are cognitive dysfunction and life threatening diseases like cancer or primary organ failure, and/or severe mental diagnosis like psychosis or severe depression, or other loss of function that prevents the person to express their own free will. Persons with language barriers have been offered an interpreter at the time of data inquiry.

The initial sample size contained of 178 individuals. By the time of second measurement, 32 individuals had dropped out due to poor health conditions, death or personal reasons. Thus, the final sample size amounted to 146 individuals (N = 146) that had a mean age of 83.2 years (SD = 8.02).

Of these 146 individuals 61 % were assigned to the IHR treatment. 71 % were female and a majority, 80 %, applied for aid for the very first time. 70 % marked their marital status as single. The most common level of education was elementary school 60 %, followed by gymnasium 24 %, followed by university degree 16 %.

4.3 Material

The empirical data is derived from two questionnaires answered by the respondents. The first questionnaire, GP-CORE, aims at measuring psychosocial wellbeing. The second one is unnamed and mainly checks for background variables.

4.3.1 GP-CORE

General population - Clinical outcomes in routine evaluation (GP-CORE) is the main instrument for analysis in this study. It is a downscaled utility for measuring psychological wellbeing from the larger CORE OM (Clinical outcomes in routine evaluation-Outcome measure).

GP-CORE was originally developed by Sinclair & Barkham (2005) to evaluate psychological wellbeing for people outside of clinical care environment. The evaluation is done by using several items from the original CORE OM. The removed items are specifically targeting information that is relevant for a clinical environment. GP-CORE has only been tested on British students previously but is believed to be useable on other populations as well, such as older adults. This study is the first time it is used and tested with Swedish older adults, which
requires a special validity analysis (research question 1) before moving on to the main research questions for this study.

The GP-CORE questionnaire consists of 14 questions which all are answered by ticking a five point likert scale. Stretching from: (0) never to (1) rarely to (2) now and then to (3) often to (4) almost always. The total score of an individual is divided by 14 to compute a mean value that is used as a measurement of psychological wellbeing. A higher value indicates a higher level of psychosocial distress. The scale stretches from 0 to 4.

Further, the GP-CORE suits the aim of this study particular well (to present an understanding of how psychosocial wellbeing can increase amongst older adults after a hospital stay by implementing IHR) because the items that measure psychological wellbeing do that by also including the coping of everyday struggles in a social dimension. As has been described in the key concepts (section 1.1), psychosocial wellbeing is conceptualized and used scientifically as a term that places heavy reliance on the relationship between social interaction and psychological wellbeing. The GP-CORE items targets the psychosocial variables used by Palacios, Torres and Mena (2008) to a satisfying degree.

Table 1. Shows which of the GP-CORE items corresponds to what variable of psychosocial wellbeing proposed by Palacios, Torres & Mena (2008).

<table>
<thead>
<tr>
<th>Psychosocial variables by Palacios, Torres &amp; Mena (2008)</th>
<th>Corresponding GP-CORE items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living situation</td>
<td></td>
</tr>
<tr>
<td>Mutual dependence on others</td>
<td>2, 8, 10, 12</td>
</tr>
<tr>
<td>Subjective health</td>
<td>1, 5, 3, 7, 11</td>
</tr>
<tr>
<td>Primary care contacts</td>
<td>5</td>
</tr>
<tr>
<td>Feeling one’s age</td>
<td>4, 13</td>
</tr>
<tr>
<td>Community participation</td>
<td>12, 10,</td>
</tr>
<tr>
<td>Physical activity</td>
<td>6, 9, 14</td>
</tr>
</tbody>
</table>

By this argumentation, it has been decided that the GP-CORE can be used to measure psychosocial wellbeing amongst the Swedish older adults. Therefore, the results from the GP-CORE questionnaire will from now on be referred to the level of psychosocial wellbeing amongst the participants.

Eight of the fourteen items are positive (Item 2, 3, 4, 6, 8, 9, 13, 14). This means that a high score is associated with a low measurement for psychological distress. For example, item one asks: “During the last week, I felt tensed, anxious and nervous”. And item two asks “During the last week, I have felt that I have somebody to turn to when I need it”. Answering “never” on the first question would imply a good psychological condition, but a bad ditto if ticked on
the second question. Thus, to be consistent with how the GP CORE and CORE OM are used elsewhere, the positive items are turned so a high score corresponds with a high level of psychosocial distress and low values indicate psychosocial wellbeing.

When analysed for reliability, the GP-CORE performed a Cronbach’s alfa value of .78 at time point 1, and .8 at time point 2. Both values are above the threshold of .7 that is generally considered an acceptable indication of unidimensionality (Field, 2013).

4.3.2 Other material

The second questionnaire has no name and is primarily used for background information about the respondent’s age, gender, civil status, and educational background.

Life, - and health satisfaction were taped by letting the respondents place themselves along a line where the most left represented the worst possible state. And the most right the best possible state. The distance was then measured and converted into centimetres which is also the units used to describe the respondent’s life, - and health satisfaction.

The statistical analyses have been conducted with the computer software IBM statistical package for the social science (SPSS) version 22.

4.3.3 Procedure of research review

The research review was carried out using two interdisciplinary search engines: Academic search elite, and Web of science. The two were chosen due to their interdisciplinary character as the reablement teams are strongly interdisciplinary which would motivate the use of research from several different fields.

The main interest in this research review has been the meaning of social elements in the reablement process. To target this and the field of social work in reablement, the following search strings were used in both search engines: “re-ablement OR reablement”, “re-ablement OR reablement AND company”, “re-ablement OR reablement AND social*”.

4.4 Statistical and interpretative analyses

4.4.1 Quality of data

Before starting the initial statistical analyses, the quality of the data was checked by controlling for (1) dropouts, (2) additivity/linearity, (3) normality. The aggregated results encouraged the author to decide that the quality was sufficient to be used with parametric tests. The results of these analyses can be seen in appendix A. The process for checking the data quality follows the recommendation of Andy Field (2013).
4.4.2 Research question I

*How can GP-CORE be used as a measurement of psychosocial wellbeing?*

For research question I, two types of statistical tests were made along with one theoretical analysis. The first was to check for a bivariate (Pearson’s) correlation between the GP-CORE scores and life satisfaction. Second, a bivariate correlation between GP-CORE scores and self-reported anxiety/sadness.

**Pearson’s correlation.** Pearson’s correlation uses the mean value of a variable and compares it to the mean value of a second variable. The r value (that is presented in the results) tells the reader by how much the value of the dependent variable increases (or decreases if the value is negative) every time the value of the independent variable increases by 1. The value can be anywhere between -1 to 1, which represents a perfect correlation in a positive or negative direction (Field, 2013).

Research question one aims at studying the validity of the GP-CORE questioner when used on older Swedish adults. Therefore, these analyses have been conducted using the whole sample, both from the control group and the intervention group.

4.4.3 Research question II

*In what way does IHR affect the psychosocial wellbeing of older adults?*

For the second research question, two types of statistical tests were made along with one theoretical analysis. The statistical tests studies the development of psychosocial wellbeing, anxiety/sadness, life satisfaction, and health satisfaction of the intervention group and the IHR group respectively. The first statistical test is the *t*-test that describes the movement of a parameter from time point one to time point two. The second test is the one way repeated measure ANOVA that describe the mean of a parameter of one factor in relation to that of another factor to check if they differ significantly between the time points. One way repeated measure ANOVA is especially useful when conducting experiments (Field, 2013).

**T-test.** The *t*-test uses the mean value of a parameter and compares that value to the value of the same parameter at a later time, called dependent *t*-test (Field, 2013). These values are illustrated at three different places in the report. First, each variable mean is reported in text along with the standard deviation (M = xx, SD = xx). Secondly the mean is illustrated in a chart for pedagogically reasons. And lastly the formal report according to the APA style where the confidence interval, *t*-value, and *p* value is shown.

The factors are represented by the groups (IHR and control), the independent variable is time (time point 1 and 2), and the dependent variable is represented by the empirical observations.

**One way repeated measures ANOVA.** The one way repeated measures ANOVA are also presented in the same way as the *t*-tests, in text, in a chart, and report according to the APA style. When reading the results of the one-way repeated measures ANOVA, one should be especially concerned with the *F* value and the *p* value. The *F* value represents the ratio
between how much of the variance can be explained by the statistical model, and the $p$ value represents the probability that the results are generated out of chance. Generally a $p$ value below .05 is considered statistical significant (Field, 2013).

To be on the safe side, non-parametric tests were also conducted.

Finally, the results from the statistical tests are interpreted thru the knowledge found in the research review and the theoretical framework.

### 4.4.4 Research question III

*How can psychosocial wellbeing be increased amongst older adults by administrating IHR?*

Research question three is answered by merging the knowledge presented from the research review, theoretical framework and the findings from research question two. What is presented here is analytically generalizable which should be separated from the statistical generalizability sought in research question one and two.

### 4.5 Ethical considerations

The study has attained approval from the regional ethics committee in Uppsala.

There are no known physical risks in participating in this study. It is possible that the participants may feel discomfort when answering the questionnaires because it will force a reflection about their current health status. They will however not do this alone but with professional social workers alongside with them (this social worker is only present during questionnaire answering, not in the rehabilitation and treatment in any group). The participants will also, regardless of group belonging, have intensive contacts with professionals during the study.

The municipal home service providers in this study have a set of basic values that is applied also in research. The values are based on Swedish legislation concerning discrimination and equality. Explicitly for the home service providers this means that all caretakers shall be treated equally, regardless of gender, ethnicity, religion, sexual orientation or disability.
5 RESULTS AND ANALYSIS

The results and analysis of each research question are presented one by one. The interpretative analysis follows directly after the results of the statistical tests.

5.1 Research question I

In the present study, there is a significant negative correlation between the mean GP-CORE scores and that of Life satisfaction before any treatment (IHFR or municipal services) were deployed. There is also a positive correlation between the mean GP-CORE scores and the participant’s self-reported anxiety/sadness before any treatment were deployed.

Correlation between mean GP-CORE and life satisfaction, \( r = -0.386 [-0.537, -0.229], p = .000 \)

Correlation between mean GP-CORE and anxiety/sadness, \( r = 0.472 [0.340, 0.592], p = .000 \)

5.1.1 Validity

Palacios, Torres & Mena (2009) has argued for using the variables (1) living situation, (2) mutual dependency on others, (3) subjective health, (4) healthcare contacts, (5) feeling one’s age, (6) community participation, and (7) physical activity, as viable variables for measuring psychosocial wellbeing. GP-CORE, as has been showed in section 4.4.1 corresponds to all of the areas except for number 1, living situation (see table 1).

Living situation aims at taping in to whether the individual is sharing household with anyone else, an important measurement of everyday social interactions that is not captured by the GP-CORE. This should be considered when using the instrument if such arrangement is important for what is studied. However, the number of cohabitants doesn’t necessarily say anything about the quality of the social interactions and how such quality impacts the aggregated psychosocial wellbeing.

There seems to be two major arguments for validating GP-CORE as a measurement for psychosocial wellbeing and one against. (1) The correlation tests show statistical significance, both the negative one for anxiety/sadness and the positive one for life satisfaction. Both correlate to the GP-CORE scores at roughly the same strength. (2) The GP-CORE performed an acceptable Cronbach’s alfa value at time point 1 and time point 2, meaning that the items in the questionnaire align with each other. The argument against using the instrument is that it taps in to 6 of the 7 identified variables of psychosocial wellbeing by Palacios, Torres & Mena (2009).

A reasonable question then arises, if GP-CORE doesn’t cover all 7 variables, why use it as a measurement for psychosocial wellbeing at all? The strength of GP-CORE over other instruments is that GP-CORE is general and it is open for all to use, there is no license required for usage. This has made the instrument very popular and so there are plenty of studies to compare results with. It hasn’t however been used in studies concerned with
psychosocial wellbeing (Sinclair & Barkham, 2005). This means that a study like this would for example not be able to answer whether IHR is more effective for people who are cohabitant or not.

The chances for cohabitants and non-cohabitants to get assign to the intervention or control group are equal, which controls for living situation to skew the results. With this disclaimer, the author draws the conclusion that GP-CORE is a useable instrument to measure the psychosocial wellbeing amongst Swedish older adults within IHR environment.

But for other studies, if the living situation is particularly important, the researcher should consider alternative instruments to tap that field.

5.2 Research question II

The participants reported a significant decreased anxiety/sadness from time point 1 to time point 2.

They also reported a significant increase in psychosocial wellbeing, life-, and health satisfaction from time point 1 to time point 2.

However, the control group performed similar scores and the difference between the IHR group and control group was not significant. This means that something had an effect on both the IHR group and control group that caused their anxiety to decrease, and their rate of psychosocial wellbeing, life satisfaction and health satisfaction to increase. The results cannot confirm a causal relation between the IHR treatment and the general increased wellbeing amongst the participants.
5.2.1 Psychological wellbeing

On average, participants in the IHR group increased their psychological wellbeing from time point one (M = 1.31, SE = .07) to time point two (M = 1, SE = .06), the difference is significant, .3, BCa 95% CI [.2, .42], t(70) = 5.51, p = .000. The participants in the control group also increased their psychological wellbeing scores from time point one (M = 1.41, SE = .1) to time point two (M = 1.08, SE = .1), the difference is significant, .33, BCa 95% CI [.14, .51], t(70) = 3.3, p = .000. The increase from time point one to time point two between the IHR group to the control group are not significant F(1, 111) = .053, p = .818.

Also the non-parametric correlations (Spearman) showed the same development and significance.

Figure 2. Shows the development of psychosocial wellbeing from time point 1 to time point 2 in the IHR, - and control group.

![Graph showing estimated marginal means of MEASURE_1 over time for IHR and control groups.](image-url)
5.2.2 Anxiety/sadness

On average, participants in the IHR group decreased their anxiety/sadness from time point one ($M = .92$, $SE = .06$) to time point two ($M = .8$, $SE = .09$), the difference is not significant, $t(70) = 1.13, p = .26$. The participants in the control group also decreased their psychological distress scores from time point one ($M = .79$, $SE = .14$) to time point two ($M = .69$, $SE = .13$), the difference is not significant, $t(41) = .64, p = .52$. The decrease from time point one to time point two between the IHR group to the control group are not significant $F(1, 111) = .010, p = .92$.

Figure 3. Shows the development of anxiety/sadness from time point 1 to time point 2 in the IHR, - and control group.
5.2.3 Life satisfaction

On average, participants in the IHR group increased their life satisfaction from time point one (M = 58.9, SE = 2.75) to time point two (M = 71.2, SE = 2.56) the difference is significant -12.3, BCa 95% CI [-18.5, -6.3], t(70) = -4.07 p = .000. And the participants in the control group also increased their psychological distress scores from time point one (M = 61.8, SE = 4.07) to time point two (M = 68.14, SE = 3.69), the difference is significant, -6.4, BCa 95% CI [-12.8, -31], t(41) = -2.03, p = .049. The increase from time point one to time point two between the IHR group to the control group are not significant F(1, 111) = 1.675, p = .198.

Also the non-parametric correlations (Spearman) showed the same development and significance.

Figure 4. Shows the development of Life satisfaction from time point 1 to time point 2 in the IHR, - and control group.
5.2.4 Health satisfaction

On average, participants in the IHR group increased their health satisfaction from time point one (M = 50.31, SE = 1.99) to time point two (M = 60.21, SE = 2.04), the difference, is significant, -9.9, BCa 95% CI [-14.44, -5.35], t(70) = -5.4, p = .000. And the participants in the control group also increased their psychological distress scores from time point one (M = 48, SE = 2.99) to time point two (M = 61.67, SE = 3.12), the difference is significant, -14.17, BCa 95% CI [-19.88, -8.34], t(41) = -5.12, p = .000. The decrease from time point one to time point two between the IHR group to the control group are not significant F(1, 111) = 1.386, p = .242.

Also the non-parametric correlations (Spearman) showed the same development and significance.

![Estimated Marginal Means of MEASURE_1](image)

Figure 5. Shows the development of health satisfaction from time point 1 to time point 2 in the IHR, - and control group.

5.2.5 IHR is not the (sole) cause of psychosocial wellbeing

The main findings in this study are that there is no causal relation between IHR treatment and increased psychosocial wellbeing amongst the older adults. In general, the participants reacted in much the same way across all variables, regardless of the group belonging. Because both groups increased their psychosocial wellbeing, one should examine what the groups have in common, rather than what separates them to interpret the result. Why do they
respond in roughly the same way to two different interventions? Are there confounding variables?

The participants in both groups are about the same age and they both got some intervention (the control group got ordinary municipal home service). According to Dahl, Eskelinen & Hansen (2015) there are similarities but also fundamental differences to a reablement process and the help-to-self-help approach that is already widely (and informally) adopted by the service workers in Sweden. Both the help-to-self-help discourse, as well as IHR aims at increasing psychological wellbeing by achieving individual independence and dignity. But with different course of action.

Another commonality is that the level of social interactions has increased as both home service and IHR intervention means that professionals comes to visit the person in their homes to work with them. This indicates that it is not the IHR treatment per se (including a social worker as social counsellor) that is the factor for increased wellbeing. Instead, a plausible confounding factor could be the increased social interaction that occurred in both groups. According to the role theory, transcending from one age to another (these individual is experiencing the transition from healthy senior to fourth age) comes with an initial loss of roles. When a person loses a role that means status or prestige, it is usually associated with distress and anxiety (Goffman, 1963). But when introduced to a new setting, such as receiving home care services or IHR treatment, new roles (that offers understanding of one-self in relation to the surroundings) and new protocols (that offers instructions of how to interact with different symbols) are established in which a person can find support. From a role theory perspective, it would seem like it isn’t so much the intervention that causes psychosocial wellbeing, but rather the social relationships and new roles/protocols it brings with it.

One would expect the IHR group to increase their psychosocial wellbeing significantly in relation to the control group as the IHR received special treatment to increase psychosocial wellbeing (sessions with the social counsellor). But instead the IHR and the control group increased their wellbeing in all areas at roughly the same rate. This may be a result of people playing their roles better with practice. Those who work with home care services are used to working inside of people’s homes. The municipal home care service is a field where the professionals already possess a protocol for the very intimate situations that plays out in that environment. According to the role theory, this means that they can socially navigate a person’s home skilfully and still create a good relation with the older adult. IHR are a new treatment, which means the professionals are not as experienced in working inside the homes of older adults as the home service staff workers is. The new work environment could cause role confusion also for the professionals, which may affect their ability to tie relational bounds. In other words, IHR may have a positive effect on psychosocial wellbeing but could be inhibited by a role confusion that is not present in the control group (note that this only applies to the academically professionals, the service workers in the IHR group have a long history of working in the home services).
5.3 Research question III

The combined knowledge of this study mainly points towards the importance of IHR professionals to be able to build an environment around the older adult where new roles and social protocols can grow, and old ones to be advocated.

In this analysis based on the empirical findings, research review, theoretical frame (symbolic interactionism and role theory), and the specific circumstances of the IHR intervention, a picture is drawn of the importance of participation, and the social professionals.

5.3.1 Barriers to build relations, and increase participation

The professionals who are part of the IHR team are very well educated. Amongst them one can spot nurses, physiotherapist, doctors, social workers etc. (Nancarrow, Shuttleworth, Tounge & Brown, 2005). With so much education and expertise it may be hard for an older adult to speak one’s mind and to have an opinion that goes against that of the professionals. In short, one could theorise that participation has less chance to be extensive when an older adult is being cared for by a well-educated professional, then that of a short educated one. Participation in a care or reablement process is very important from a role theory perspective for the same reasons that are mentioned in the section above (loss of roles/role confusion). But also from the perspective of symbolic interactionism.

We humans’ use symbols to understand, make sense and operate reality (Mead, 1910). Everything can be interpreted as symbols; an academic degree is a symbol that may be seen as an inequality factor. The social interaction between two peers have a different symbolic value than that between i.e. a helper and a receiver, a professional and a layman etc. It is likely that the highly educated team of professionals with various university degrees recommends approaches, goals and treatments based on the best available knowledge. For an older adult who recently begun to lose prestigious roles and who doesn’t have access to the same academically knowledge, it may be hard to argue against such recommendations. A majority of the sample have an elementary school background (60 %) and 24 % have a gymasia background. It is easy to imagine that it must be hard to claim participation in the caring process when the counterpart has a university degree and are an expert in his/her field with much experience.

5.3.2 Social work in the IHR process

Even though the participants in the IHR group did increase all their points of measurements (psychosocial wellbeing, life satisfaction, and health satisfaction), it is hardly satisfying that the group did not significantly differ from the control group. This calls for a reflection concerning how to use social workers in the IHR process, as no casual relation were found between the use of a social counsellor and increased psychosocial wellbeing amongst the older adults.
The access to professional knowledge also means an offset in the power relation between the helper and the helped. The power relation between the older adults and the professionals in the IHR team are asymmetrical in a way that is not the case within the home service staff (the control group) seen to the access to professional knowledge. This analysis would need support from more empirical data, but nevertheless points out an important research area that needs to be explored to gain insights of how participation is created within the care of older adults. The finding is also very important to understand the role of social work within an IHR context. Few professions have more experience and theoretical knowledge in handling asymmetrical power relations then social workers. Perhaps social worker’s expertise could be used strategically in management positions to increase the possibilities for social relations to become stable, handling asymmetrical power relations and widen the view of re-ablement, from solely somatic to bio-psychosocial. To use social workers as IHR team managers finds support by the work of Lewin, Concanen and Youens, (2016). As team managers, the social workers could ensure that the way paved for protocols to develop and offer new roles for the older adults and the professionals. Lewin, Concanen and Youens, (2016) doesn’t specifically point out social workers as the ideal managers, but rather some profession outside of the traditional healthcare professions that have a more biopsychosocial approach to health and independence. This suggestion also aligns with the governmental vision of the future care for older adults (Swedish ministry of social affairs, 2008) that point towards the importance of applying a holistic view of reablement. Reablement must be seen from a wider scope then just regaining lost bodily functions, but also strengthens social relations and enhancing independence and participation.

Social relations can be that of friends and family, but also caring professionals and those in the immediate circle around the older adult. The results of this study show that psychosocial wellbeing seem to increase regardless of the older adult get to talk to a social counsellor or not. The development seems to be independent of counsellors or other professionals with a higher education. But rather closer relations with workers who can make the older adult regain new roles and by that creating new social meaning and understanding of him/herself. This finding is important for anyone who wants to live up to the goal of widening the scope of reablement to include psychosocial wellbeing. A constellation with a social worker as team manager would also enable a closer collaboration between the social workers and the service workers, who has the greatest possibilities to create new and safe roles as they spend the most time with the older adult. That way, the two professions (and others) would be able to co-ordinate their work for optimal increased psychosocial wellbeing. Also, if the co-ordination between social and service workers increase, the social goals and repetition of goals could be moved up the prion list. Lack of goals and lack of goal communication is problems that have been described as hugely important, yet often insufficient for the reablement process by Glendinning et al. (2008).

It is also important to note that this study measure the impact of the IHR intervention as a whole, not just the work of the social counsellors. This means that it is fully plausible that the counsellors do have an effect on the psychosocial wellbeing of the older adults, but needs to be administrated more frequently to show statistical significance. The results do not discredit the social counsellors of the IHR intervention.
6 DISCUSSION

The aim of this study is to explore how psychosocial wellbeing can be increased for older adults by implementing intensive home rehabilitation after a hospital stay. Psychosocial wellbeing amongst older adults is a prioritized area for the future care system in Sweden (Swedish ministry of social affairs, 2008). In this study psychosocial wellbeing is measured as a) the absence of psychosocial distress, b) the absence of anxiety/sadness, c) the presence of life satisfaction, and d) the presence of health satisfaction. All of which has been measured in a group of IHR participants (intervention group) in relation to a group with traditional home care services (control group), and interpreted with symbolic interactionism and role theory.

6.1 Results discussion

The main findings have shown that (a) the GP-CORE questionnai re is useable to measure psychological wellbeing amongst older Swedish adults, (b) IHR did not increase psychological wellbeing amongst the sample. It did increase, but at the same rate as the control group. A plausible explanation for the finding is the increased social relations that both groups experienced during the experiment. (c) psychosocial wellbeing could increase amongst the IHR recipients by ensuring that the IHR professionals are able to build an environment around the older adult where new roles and social protocols can grow, and old ones to be advocated.

6.1.1 Contributions to the practical field of social work

The findings of this study are encouraging for anyone who works with building relations with older adults. It seems like the closer and more informal relation a professional can achieve with an older adult, the better are the chances to increase their psychological wellbeing. This should especially be considered when venturing further down the road to implement IHR in accordance to the aims for the future care system for older adults announced by the Swedish government.

Although social workers were included in the interprofessional team as social counsellors, this didn’t have enough effects on the participant’s psychosocial wellbeing to show statistical significance. Glendinning, et al, (2008) and Hjelle, Alvsag and Forland (2016) has shown that the goal-setting and participation in IHR process are crucial for the success of it. Here, the social workers and the service workers could be a resource for enhancing participation and goal setting. Lewin, Concanen and Youens, (2016) has suggested other professions then traditional healthcare personnel to manage the IHR teams. This is to embrace a more holistic care-view than just the somatic one. If a social worker were to fill such position s/he would be able to create platforms for safe roles, and protocols across the interprofessional team and the older adults to grow.
It remains however unclear whether the social counsellors had no effect or whether it was simply insufficient in its current form (and needs more involvement in the IHR process to show effect). This is important knowledge for developing future IHR interventions; the social counsellor should not be ruled out as a part of IHR teams. Especially considered that there was a period during the intervention that the counsellor left the job and it took a few weeks to replace it.

6.1.2 Contributions to the academically field of social work

The academic contributions of this study are mainly that the GP-CORE questionnaire can be used as a measurement of psychosocial wellbeing and not only psychological wellbeing. This opens doors to further tap in to the field of how psychological wellbeing can be stimulated by social work and social workers.

It is clear that the future of the care system is complex; it involves many professions and these needs to speak the same language, both professionally and academically. GP-CORE has its roots in the psychological tradition but its use is expanding also into the field of social work. Having measurement scales that applies to a wide set of professions and academic fields (and traditions) is one step on the way towards greater consensus and by that greater abilities to put all processional knowledge to the best practice.

Aside from crossing academically borders and traditions, this study also draws some conclusions that rest heavily on the theoretical suppositions of Goffman (1959; 1963) and Mead (1910; 1922; 1932; 1938). For example, that stable social relationships are dependent on roles, which in turn affect the psychosocial development of older adults. Or that social symbols are factors of asymmetrical power relations that can affect the participation in the IHR process amongst older adults. These conclusions must of course be studied more in depth then what is possible within the frame of a master thesis. They do however provide a platform for analysis and guidance for further research in the field of psychosocial wellbeing within the care system of older adults.

6.2 Methodological discussion

When using a pre-test, the different baselines will reveal how well the randomization process has worked. If both the intervention group and the control group show roughly the same scores before any intervention is introduced, the randomization was successful. It also enables to check for ceiling or floor effects, which means a person self-evaluated him/herself at the lowest or highest possible score at base line (Christensen, 2010). The randomization process of this study was successful, both groups started out roughly at the same level of psychosocial wellbeing, only .9 units separated the IHR, - from the control group. However, the sample size is rather small and the intervention group is 19 % larger than the control group. Having a larger sample size and a more equal number of participants in each group would yield greater statistical power which in turn would have greater ability to detect significant differences between the groups.
Using a pretest – posttest control group design carries many advantages. The most obvious is the ability to demonstrate the impact of the intervention in relation to those who get no intervention. Using a control group offers the greatest protection possible (but gives no guaranties) against sources of bias like history (something happens between the time points of filling out the survey that affects the answers), testing (the participant remembers how s/he answered the previous time and repeats it), regression artefact (if participants ticks extreme scores in the beginning of a test and then move towards the mean at time point two may cause the intervention to be overestimated) and attrition (dropouts). The protection lies in the numbers; it is mathematically likely that the presence of these types of biases is equally distributed in both the intervention group and the control group (Creswell, 2014; Field, 2013).

However, a control group can never offer a full protection to bias which means the threats needs to be kept under surveillance and the quality of data needs to be checked before being used in statistical tests (Creswell, 2014). The result of the quality check is found in appendix A.

There are however some validity threats that needs to be considered, even when using a fairly robust design like the pretest – posttest control group design. The most immediate threat would be that of unknown confounding variables that is not captured by the questionnaire. There are many things that can affect a person’s psychosocial wellbeing that is impossible to control for. Also, psychological wellbeing is highly subjective and may change from one part of a day to another. However, having a control group and a fairly large sample as is the case in this study, chances are good of such bias being represented equally in both the intervention, - and the control group. In fact, having a control group neutralises most validity threats to a satisfying extent (Creswell, 2014).

When conducting research amongst older persons with diseases/disabilities one obvious validity threat is attrition due to mortality. The sample used for this study had a total drop out of 32, the most common reason was death and severe illnesses like Alzheimer’s disease.

In terms of reliability other than bias managing, this study is designed to be fairly easy to replicate. IHR is gaining foothold around different municipalities in Sweden, which offers good possibilities to replicate this study. Apart from just looking at psychosocial development within IHR, it would be necessary to keep testing the GP-CORE questionnaire’s ability to conceptualize psychosocial wellbeing amongst older adults. The internal consistency reliability of this study is also decent; all variables developed towards increased wellbeing and decreased anxiety amongst the sample.

It may also be important to remember that Rabiee and Glendinnin (2011) have shown that not all older adults are eligible for the IHR intervention. The IHR shows good results on those who are eligible, but there is a threshold as to when reablement no longer causes a person to regain their abilities. It is unclear how such cases have affected the results of this study because such bias would only be represented in the IHR group.
6.3 Ethical discussion

As stated earlier, the study has attained approval from the regional ethics committee in Uppsala.

The older adults of this study has agreed to participate in the research project during the planning session of the continuing care process at the hospital. During the session, the assessment officers made sure all four ethical obligatorium of the scientific council (vetenskapsrådet, 2017) were achieved. These includes informing the participant of the aim of the research, attaining consent for participation from the older adult, guarantee of confidentiality, and pledge of usage (that the researcher will not use the information in any other way then has been approved by the participant).

However, the consent is not unproblematic as it was given at the hospital right before being discharged. This is a potential stressful situation for the older adult and it is unknown to the author of this study the state/shape of the older adults at the time of giving their consent. But, the assessment officer that received the consent are trained social workers and do have the expertise to make such evaluation. They are also the ones who screen the participants for the inclusion/exclusion criteria’s, which force them to reflect on the shape of the individual.

Even though no participant has reported any discomfort that can be linked to the process of this study, it is likely that the completion of the survey is experienced as repetitive and dull. It could also force a reflexion over the state of one’s health status that could potentially be stressful. The participants do not fill out survey by themselves but are accompanied by professional social workers. Afterwards, they have also had the option to directly contact the researchers to request help or inform about discomfort. No such contact has been made.

6.4 Further research

Based on the findings of this study, further research should mainly be aimed at looking into what specific factors it is that causes the psychosocial wellbeing so that such factors can be considered when assembling an IHR team. For example, both the results of this study and those of previous research has pointed towards using social workers as managers or team leaders to increase the holistic approach of IHR treatment. The result of such team composition would need to be studied. And also how such constellation can increase awareness and ability to handle asymmetric power relations to increase the participation of the older adult and of the service workers in the interprofessional team.

Lastly, this study cannot rule out the efficiency of social counsellors. It should be studied if more frequent social counselling, or under different forms could increase psychosocial wellbeing to an extent where statistical significance can be observed.
7 CONCLUSIONS

GP-CORE is a usable instrument for measure psychosocial wellbeing amongst Swedish older adults. When the instrument was used to see if the IHR treatment increased the psychosocial wellbeing of participants in this study, it showed that the IHR treatment itself did not cause an increase of psychosocial wellbeing amongst the older adults. But something caused their psychosocial wellbeing to increase, something that this study did not test for. With support from previous research and role theory/symbolic interactionism the results could be interpreted as it is the quality of the relations between the helpers and the caretakers that increases the psychosocial wellbeing.

If sustainable psychosocial wellbeing is to be enforced, this study suggests that social, - and healthcare professionals should concern themselves with creating contexts where supportive roles and protocols can grow. For example, organising work conditions for social, - service, - and healthcare workers have as good opportunities as possible to develop their social relation with the older adults. When the older adult engages in these social relations s/he should develop new roles to master, which can decrease the stress of role loss and role confusion. But also give the older adult new protocols to handle the new social situations, offering security and all together: psychosocial wellbeing.
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APPENDIX A; QUALITY OF DATA

Dropouts
The initial sample size contained 178 individuals. By the time of second measurement, 32 individuals had dropped due to poor health conditions, death or personal reasons. Thus, the final sample size amounted to 146 individuals (N = 146).

Additivity/Linearity
Additivity/linearity means that the dependent variable (gp-core, anxiety, life satisfaction, health satisfaction) has a clear determination based on the independent variable (time). These variables need to be evaluated test-by-test and the results are shown under each test section (5.2.1, 5.2.2, 5.2.3, 5.2.4). All dependent variables showed a significant movement between the time points and thus the additivity is satisfactory.

Normality
Normality is determined with a histogram over the main variable of this study, the gp-core variable. The normality curve can be seen below.

Normal distribution of all participants at time point 1:
Normal distribution of IHR group at time point 2:

Normal distribution of control group at time point 2: