Developing Resident Relationships in Nursing Homes

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Abstract

Studies have shown that building relationships is important for maintaining and improving health, but there has not been a narrative account of how these relationships are developed in elder care facilities. The purpose of this qualitative study is to obtain a better understanding of how adults living in nursing facilities develop new relationships with other residents. Results will look at strategies for receiving social support and building meaningful relationships. The stories I have collected present the real faces of the aging population, and demonstrate the many opportunities we have to grow meaningful relationships in elder care facilities. By understanding these relationships, we can foster more successful relationships in and out of skilled nursing facilities, which might lead to better outcomes in health and well-being for the growing elderly population.

Introduction

Over the past century, changes in demographic trends (life expectancy, family roles) and economic trends (shift in labor market, the Great Depression, and the Social Security Act) made nursing homes an appealing form of care for the elderly. Nursing homes still fill a vital social role today and reliance on these facilities will intensify as the elderly population grows. By the

year 2030, one in five Americans will be over the age of 65, constituting 70 million people in this age group (Nagappan & Parkin, 2003). Comparatively, the 2000 U.S. Census captured 35 million people above the age of 65, meaning that this population will have doubled in the span of just three decades (U.S. Census 2001). Some of the issues that have always surrounded elder care, such as fiscal and social responsibility for elder care, persist. Caretaker roles continue to evolve -- women are more likely to be in the workplace than before, so they are not able to fill the traditional role of caretaking for elderly parents (Bookman and Kimbrel, 2011). Or, if they do take on caretaker responsibilities, women risk lost opportunities in the workplace (Bookman and Kimbrel, 2011). In the financial dimension, there are still many people who cannot afford long term care – especially the working power and lower middle class, who are too poor to pay for care, but too rich to qualify for aid (Bookman and Kimbrel, 2011, Knickman and Snell, 2002).

There are also various issues that surround nursing homes themselves. Although there are many laws in place to protect the rights of nursing home residents, there are still gaps in the quality of care they receive. In physician Atul Gawande's book *Being Mortal*, he expresses how nursing homes typically meet health and safety needs, which are especially important to family members of the residents and to governing bodies (2014). However, Gawande explains how many social and emotional needs are not being met, which are especially important to the guests themselves.

There is a large body of research demonstrating that strong social relationships buffer against poor health outcomes and are related to general increases in perceived well-being (Cobb, 1976, House, Landis, and Umberson, 1988, Uchino, Cacioppo and Kiecolt-Glaser, 1996). Social support, which involves both "the degree to which one is socially connected" and one's

"availability of social resources," is commonly researched by types of support (tangible, instrumental and emotional support) and sources of support (partners, family members, friends, etc.), and can be assessed objectively or subjectively (Tomaka, J., Thompson, S., Palacios, R., 2006). Social support is an important factor for human health and well-being, as well as in adjustment to health prognoses and stressful life events (Wethington and Kessler, 1986, Uchino, Cacioppo and Kiecolt-Glaser, 1996).

Social support is important for older adults in specific ways. In particular, a sense of "belongingness" (relationships with friends, neighbors, or organized groups) has been shown to be significant in improving health outcomes for the elderly (Tomaka, Thompson, and Palacios, 2006). Social support has also been shown to be important for older adults in minimizing the impacts of stress on mental health and improving physical health (Cutrona, C., Russell, D., & Rose, J., 1986). In addition to improving health outcomes, studies have shown that social relationships are important to improving the quality of life for nursing home residents and levels of life satisfaction (Bitzan and Kruzich, 1990, Custers et al., 2012). While social relationships are important for older adults, there are certain challenges that they might face in maintaining social relationships when they enter nursing homes. Residents in one study reported that while staff supported their daily routines such as bathing and feeding, they felt a lack of social intimacy (Mattiasson, A. and Andersson, L., 1997).

Nonetheless, older adults may have different patterns of social support as they age. Socioemotional selectivity theory posits that as people age, their perspective of the time they have left in life (time perspective) decreases. When older adults perceive that their time left is limited, they increasingly become less knowledge-seeking and more emotion-seeking, and create

goals that are "related to feelings, such as balancing emotional states or sensing that one is needed by others" (Carsensten, Fung, and Charles, 2003). In terms of social relationships, this means that older adults are more likely to focus on their closer and longer-lasting relationships, such as with family and spouses. There is more emphasis on improving those relationships and less on acquiring new friendships. This theory explains how older adults might prefer social support that is emotional and is provided by close family and friends.

While socioemotional selectivity theory emphasizes the importance of sustaining emotionally meaningful relationships with family and friends in later life, it is evident that these are not the only types of relationships that exist in nursing homes. Nursing home residents do establish relationships with other residents (Roberts and Bowers, 2013, Bergland and Kirkevold, 2008, Hubbard et al., 2003, Powers, 1991). Based on socioemotional selectivity theory, older adults living in nursing facilities might tolerate "knowledge acquisition" when meeting other residents if it results in the more optimal "emotional closeness." Furthermore, based on Goffman's theory of institutionalization, those living in total institutions such as nursing homes have lack of control over their individuality and their environment (Goffman 1961). There might be times in which resident interaction might be necessary in order for residents to feel more control over their situation. Regardless of why these relationships exist, only a few studies have explored how these relationships are established and developed (Roberts and Bowers, 2013, Bergland and Kirkevold, 2008, Hubbard et al., 2003, Powers, 1991).

Thus far, many studies have focused on families and staff members as being the source of social support, as opposed to other residents. When researchers have examined resident to resident relationships, they have mostly explored the amount of participation, predictors for

participation, and outcomes (Tomaka, Thompson, and Palacios, 2006, Mor et al., 1995). Furthermore, the practical implications of current studies focus on how staff can be more attentive to the challenges of resident interactions and better facilitate positive relationships (Cook and Clarke, 2010). There have been very few studies that have looked at how residents navigate meeting other guests, and how those relationships grow and develop meaning.

Dr.Atul Gawande advises how meaning can be achieved in nursing home relationships (2014). Gawande explains how there is a lack of compassionate care and sense of reciprocity ("mutual sharing or giving" which "helps to sustain self-worth" (Rash, 376)) for those living in skilled nursing facilities. Gawande offers some suggestions for improving nursing home care by outlining some of the most successful nursing home programs – highlighting interventions with animals, local daycares and elementary schools, and music therapy. The overarching theme in these programs is that patients should be treated on a more individualistic level, placing emphasis on the desires of each patient, which often includes having a greater sense of purpose outside of the mundane tasks of institutional life. Being able to take care of a plant, tutor a child about the war, or showcase talents to an audience can provide a sense of contributing to a greater good and leaving a legacy – a wish that many have in their last years. Although these programs have been successful in many facilities, they are not implemented in each one. They are often implemented by certain employees that care to take the next step – by no means are they required by facilities or the government. Gawande's ideas about improving care in nursing facilities through meaningful programming are supported by research on social support.

The purpose of my research is to explore how nursing home residents find emotional closeness in both new and old relationships. By understanding these relationships, and what is

valuable about social relationships for older adults, we can foster more successful relationships in and out of skilled nursing facilities, which could lead to better outcomes in health and well-being for the growing elderly population.

Methods

Methodological Approach

I used a modified version of grounded theory to produce and analyze the data set. Grounded theory is an inductive theory in which codes and themes are derived from the data itself. In grounded theory, the researcher should continue interviewing until there is enough detail to support emerging themes. I chose this theory because I wanted my themes to come from the lived experiences of the guests, and not my preconceived notions of their experiences. The goal was to talk to participants that had a range of negative and positive social experiences, so I constantly went back to the data to see which experiences were missing, continuing interviews until these perspectives were complete.

Study Population

This study took place at a nursing home in southeastern Ohio, which provides medical care for up to 111 patients at one time. In addition to therapy and rehabilitation services, the facility offers several social activities for residents. Most participants had a physical or mental disability that led them to reside at the facility.

Category	Number of Participants	% of Participants
Gender		
Male	4	26.7%
Female	11	73.3%
Total	15	
Age		
65-74	6	40.0%
75-84	7	46.7%
85-94	2	13.3%
Total	15	
Race/Ethnicity		
White	14	93.3%
Asian	1	6.7%
Total	15	
Marital Status		
Married	1	6.7%
Single	9	60.0%
Widow	5	33.3%
Total	15	
Length of time at facility		
< 1 year	5	33.3%
1-4 years	5	33.3%
5+ years	5	33.3%
Total	15	

This table shows the demographics of the sample population. Nearly ¾ of the sample was female, and ¼ male, which was expected considering most of the nursing home population was female. Since the life expectancy of females is longer, nursing homes typically care for more females than males ("Nursing Home Data Compendium" 2015). Talking to both females and males allowed me to explore social relationships in a diverse group of individuals. The ages

ranged from 65 to 92. 40% of the sample was aged 65-74, and 47% of the population was 75-84. The remaining 13% were over the age of 85. I chose these age groups based on the alignment of the age groups set out by the Center for Medicaid and Medicare Services ("Nursing Home Data Compendium" 2015). My sample includes people from each group, suggesting diversity in age. In this study, I wanted to look for any variations in social experiences based on the age of the participants. All but one of the participants were white, which also reflects the general population at this facility, and of the population of the broader region. Only one of the participants was married, while the others were either never married or widowed. The sample was evenly distributed among the 3 categories of time spent at facility – short term (>1 year), semi-long term(1-4 years), and long term(5+ years). This allowed me to collect data that reflected experiences in all stages of adjustment to in-facility care.

Data Collection

Coordinators of the activities department at the nursing home introduced me to potential participants. I was only introduced to patients that were over the age of 65 and legally competent. 15 patients agreed to be interviewed. Participation was voluntary and not related to the care the participants received at the facility.

The interviews conducted for this study took place in the private rooms of residents at the facility. The staff recommended that the I asked for consent verbally, so as to not overwhelm guests with an abundance of written information. The procedure also assured that those who couldn't read or write their name were still able to participate. The following verbal consent procedure was approved by Ohio University's IRB on 9/12/2018 (Protocol Number 18-X-261).

Prior to the interview, participants were given an information sheet which included the name, brief description of the study and contact information (*Appendix 1*). This document (and in particular, the contact information) was important for the participant or an aid of the participant to have in case they had any questions about the research. The procedures, anticipated risks and benefits were verbally communicated to the participants (*Appendix 2*). I asked participants two questions ("Do you understand that you are allowed to stop the interview at any time?" And "Do you understand that you are not required to answer every question?") to confirm their understanding of the project and their participation. They then had the ability to deny or give consent, both to participate and to record the interview. I recorded the consent process. During the interview, I took notes on pen and paper.

Questions followed a semi-structured interview schedule (*Appendix 3*) and follow up questions were asked when needed. Questions fell into six main themes – background, maintaining relationships, developing relationships, peer relationships, meaningful relationships, and meaningful activity. I asked questions depending on the nature of the conversation and what the participants offered on their own.

After the interview, the recording was uploaded to a password protected folder on a password protected laptop, and was deleted from the recorder. The laptop was always on my person or in my locked apartment. Most transcription took place via a professional transcription service (REV Transcription). I transcribed one interview in order to familiarize myself with the data and ensure audio-recording quality. The transcribed files were saved to the laptop. After transcription, the

recordings were deleted from the laptop. The written notes from the interview, which do not contain identifiable information, were kept with me at all times or in my locked apartment. All names used in the final report are pseudonyms.

I maintained an interview key: a list of participant names that are connected to the transcription file numbers (ex: Alli Evans - 001). I kept this key in case any follow-up questions arose. The list of participant names will be destroyed by April 30, 2019 per my IRB protocol. The list was kept locked in the advisor's office at Grovesnor 311. If follow-up questions arose during the data analysis period, this list would be used to set up another interview. We would repeat the consent process and ask the follow-up question(s), maintaining the confidentiality and data analysis procedures.

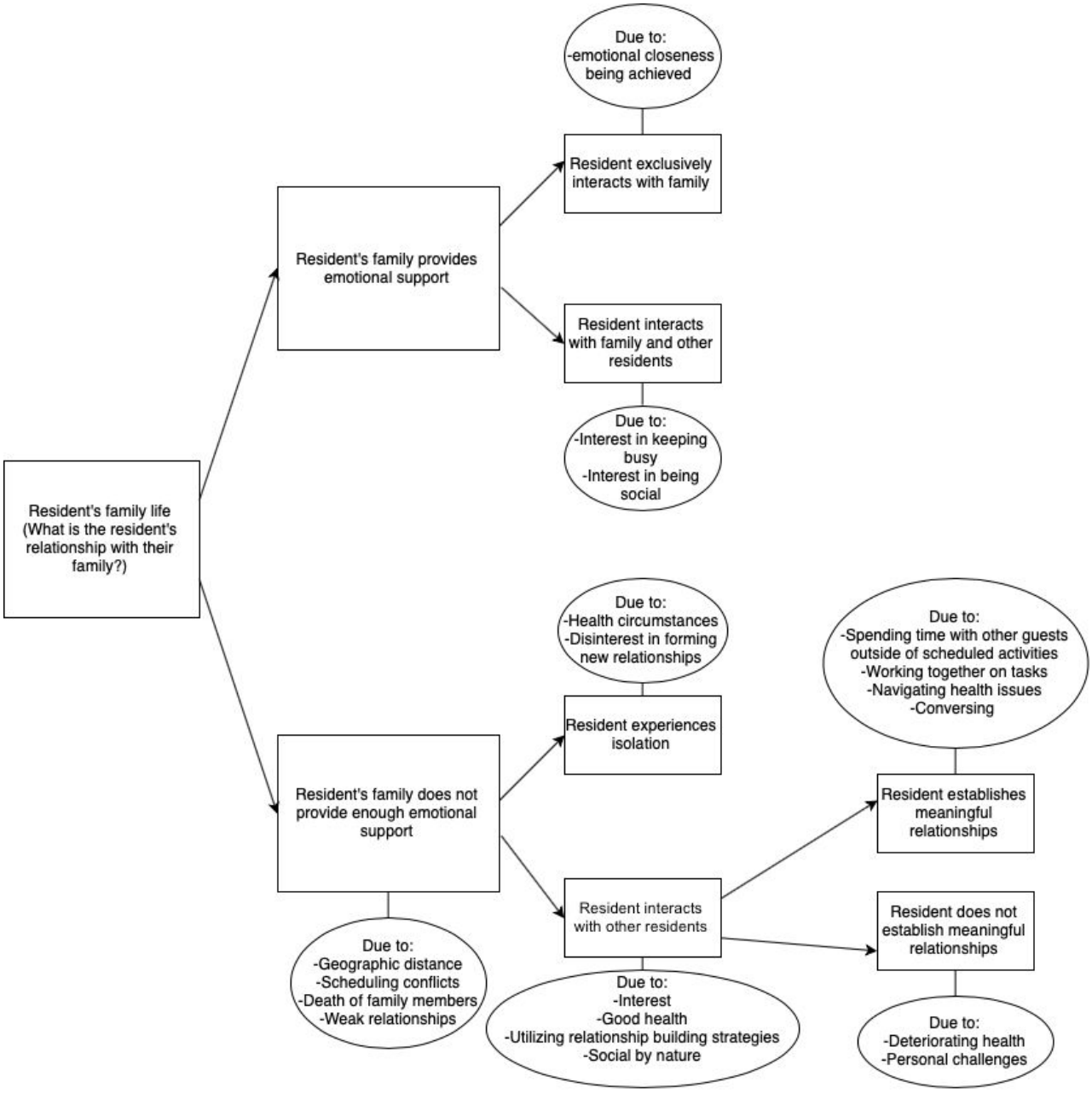
Data Analysis

I collected qualitative data through the transcription of interviews and detailed notes of those interviews. Grounded theory includes three types of coding: initial coding, focused coding, and axial coding. In the initial coding phase, I read through the transcriptions line by line and coded key words and phrases, and made memos on important ideas. I organized the codes into categories in the focused coding phase. Lastly, during axial coding I developed themes and a theory for connecting them. I then grouped my observations into the overarching themes. Through repeated analyses of these themes and terms, during and after the process of data collection was completed, I identified and collected instances of interactions that support or contradict the different overarching themes. The emerging themes relate to the social lives of adults in nursing facilities and are grounded in the lived experiences of the participants. The

themes helped me to look for the gaps in social connections. My conclusions link these themes to existing knowledge on social interaction within nursing facilities.

Findings

My findings include three overarching themes: utilizing family support, building new relationships, and achieving meaning in new relationships. Family support was meaningful for many residents. Families may provide emotional, financial, and social support, but not all residents had family members that gave adequate levels of support. Residents also formed specific strategies for developing new relationships with other patients. This was true of both residents who had adequate family support and those who did not, although the reasoning for developing new relationships differed slightly for those who had varying levels of familial support. Lastly, nursing home residents were able to establish meaningful relationships with other patients by spending time together outside of the scheduled activities, working together on tasks, navigating health issues, and conversing and sharing. However, the deteriorating health and personal challenges of the residents was a major barrier to establishing new relationships. These findings are presented visually in the figure below.



NUMBER ONE: UTILIZING FAMILY SUPPORT

Meaningful relationships with family

I found that nursing home residents' most meaningful relationships were often those with family members. Many guests explained how their relationships with spouses, children, and

grandchildren were most important to them. One participant, Millie, explained how watching her grandchildren grow up was most meaningful to her. She stated: “Well right now, it's with my boys, my two sons. And my son-in-law...Grandchildren, seein’ them envision their hopes and dreams for the future.” Bob, another patient at the facility, says his marriage is most important to him. He explained: “Well, first my wife. We’ve had a very, uh, happy marriage, ya know...55 years. And ya know, we’ve had a good life together.” In these discussions, the guests strongly valued their relationships with family and the support they received from them.

Types of support from family

Family members were able to provide emotional, financial, and social support. With support from family members, participants could have aspects of closeness, familiarity, and normal habits, hobbies, and routines at the nursing home. For example, one participant, Ann, continued receiving her mail from home because her sibling brought it to the facility. She said, “My brother brings the newspaper to me from home because I subscribe at home, he brings my mail.” Ann valued her existing routine of reading the news and was able to continue it with her brother’s support. Being able to continue routines from home allows guests to maintain some sense of normalcy while they are in an unfamiliar environment. Rob, whose son flies up from Florida about once a month to visit, says his son’s assistance was especially valuable when moving to the facility. He told me, “I just can't wait for them to get here and when my son's visits how much I appreciate his work...A lot of paperwork... I couldn't have done it [moving to facility] on my own.” Although many families continue to play a strong role in the lives of older adults, some residents particular valued support during the period of transition from home to a nursing facility. Ruth also said that her family helps to plan for her care, “I have three brothers,

and they all help in my care and finances and all that." Matters such as finding a facility, being admitted, and paying for care are aspects that families can support. Families can also play a role in providing social and recreational activities. One participant, Eloise, described how her daughter takes her out for meals, saying, "My oldest daughter sees that I go out at least once a month for dinner, or lunch, or even breakfast." Millie described how her family also provides some socialization and recreation for her through visitation.

> The visitors I have are usually my children. So, they bring, of course, my grandchildren. I usually go to the Dollar Tree and get some toys of some kind for the children. I got 'em some butterfly nets...So we would go, my children and myself, and the grandchildren, we would go out on the patio. And it'd be nice weather... they love to catch fireflies with their butterfly net.

Visits from family are often much anticipated and provide lasting memories for the residents. Family support allowed guests to continue their normal habits and hobbies, such as reading the mail and going out to lunch. Families also helped the guests navigate their care plans and finances. Through visitation and conversation, guests also received ongoing emotional support.

Lack of support from family

While many residents received various types of support from their families, there were some residents that felt their families that could not provide enough support. The lack of support was due to several reasons, such as geographic distance, work schedules, death, and weak relationships. Helen has two kids that live out of state, and two that live in state. According to Helen, her kids do not visit frequently, but might send mail. She explained, "My kids don't come. Well the one in Florida doesn't come at all. She would be more inclined, the oldest one, to send me something. She'd never forget a birthday or something like that." Although some of her kids provide periodic emotional support, they are unable to provide ongoing support due to distance

and other barriers. Margaret's kids also live out of state and do not visit frequently, which makes her feel lonely.

> Of course, my kids were where they are. Katie's in Michigan, and Randy's in Indiana. I could talk to them on the phone, but with Randy, I haven't seen him almost a year, and Katie's come down every Christmas. That makes it pretty lonely for poor me, and I didn't trust anybody. That's just my nature.

Charles, who typically has a lot of family support, explained how work schedules can get in the way of visitation. "For some reason, they were working that weekend, so they didn't come that weekend. So I missed them because usually they'll come every other day. So I had a three-day spell with nobody visiting... lonely." Even if the family typically visits frequently, there are still times when support might not be possible, leaving the resident feeling unsettled. One resident, Will, explained how he is one of the only living family members. He said, "I have no family left. They're all dead, they've all died, including my little brother. And I don't know where my older sister is at." Some residents are not able to receive support from their family members because they are no longer living. Lucy, who receives support from some family members on a daily basis, does not have strong relationships with other members of her family. She disclosed, "I have 10 grandchildren, but they don't come in. Some of them wouldn't know if they saw me on the streets 'cause their parents never brought them around...so I'm closer to some of them than others." In many cases, the nursing home residents did not receive adequate support from their family members. Even for those who did have family support, there were certain instances in which family support was not available. In these cases, many participants chose to develop new relationships with other residents inside the skilled nursing facility.

NUMBER TWO: NEW RELATIONSHIPS

Fostering old and *new relationships*

As the first theme suggests, some guests had adequate family support and some did not. I found that many who had family support still sought new relationships with other nursing home patients. Those who had family support *and* sought new relationships did so in order to "keep busy" or to "be social." Bob, whose family visits weekly, participates in nearly all social activities and encourages other guests to attend as well. He said, "I'm a people person. I just like people...they [other residents] need to get out, they need people…people sit in their rooms and watch television. And that's no good for them, so whenever I can tell someone to come out and do it, I do it." Ruth, whose family also visits weekly, finds enjoyment in building new relationships. When asked where she finds joy in relationships, Ruth responded: "Yeah, just making new friends and being able to do things with them or play a game with them or something, or meeting their family and things like that." Even if the guests maintained old relationships with family and friends, some still had considerable interest in building new relationships with other guests.

New relationships as sole socialization

For those who did not have sufficient family support, socialization with other guests was particularly important. Guests who did not have family support were in general very willing to build relationships with other guests if they had interest, were in good health, and were social by nature. Will, whose family does not visit, is social and healthy enough to propel himself in a wheelchair. He said it is important for him to build new relationships: "God didn't intend for me to just occupy my space, you know what I mean? That's why I love meeting people or having people like you like me." New relationships were the only way for some guests to have a social life. When their personality and health allowed, new relationships were often sought after.

Strategies for developing relationships

Guests, both those who had family support and those who didn't, built new relationships by participating in activities, introducing themselves, and going the extra mile to interact with other guests. Sylvia, who has lived at the facility for two years, attends the social activities organized by the staff with her new-found friends.

> Everybody I have met so far, we've gotten closer, a lot closer. They're very friendly. Of course, I'm very friendly. Get along great. We got to some of the affairs they have here...We have them every other month, an auction. And we all get together on them. We'll share what we're doing and what we're bringing down for the auction and, 'Oh, I want that', they'll say and I said them too, I got that from some lady who was gonna put it in the auction...I said, 'Let me have it, don't take it to the auction.' She said, 'Okay.' So she gave it to me.

Lorena, another guest, describes how she introduces herself to other ladies in the hallways.

> Usually if they acknowledge you there, they'll smile at you. And I just stop and talk to them. Ask them how they're feeling and if they need something, can I get them something? Most of the time they'll say no. Sometimes they'll ask for crackers or something like that.

While some residents choose to socialize in the halls or activity room, others visit with each other in their rooms. Ruth likes to visit in her friends' rooms outside of the scheduled activity times.

> Most of the older people that I was friends with have gone, but I spend time with other people outside of the activities. If I can go to their room and visit with them or something like that, I try to do that...I talk to somebody maybe once a day.

Millie explains how she meets other guests by participating in the social activities, by introducing herself and inviting others to the activities, or by visiting in the guests' rooms.

> I meet 'em in activities. Sometimes I'm introduced to 'em by one of the activity leaders...Sometimes I meet through other friends. When I can, I go to the other residents' rooms and visit with 'em. But when I can't go to their room, I will meet them on the patio or in the activity room...But I like people. I just go up to 'em and say, 'Hey, are you new here? Are you a resident? My name's Millie.' You know, 'Have you been to activities yet?' So Bingo is a good way to meet everyone…. 'course then in summertime we have cookouts on the patio.

Guests aiming to develop new relationships within the skilled nursing facility described using strategies such as participating in activities and "putting themselves out there" to meet other guests.

Lack of any type of relationship

Guests who do not have visitors, experience physical or mental health limitations, and who do not utilize strategies for forming new relationships have an elevated risk of social isolation. If guests are not healthy enough to walk or use a wheelchair, and/or choose not to form new relationships, they often spend a considerable time alone in their rooms.

Judy, who is not mobile enough to leave her room, is not interested in socialization, and does not have living family members, is isolated in her room, except when a neighbor comes to visit her.

> I do not get out of this room very often...if I wanted to I could be out there playing Bingo all afternoon or doing this, that and the other. There's a lot of activities. I choose not to...I would rather be by myself. The lady across the hallway is a good friend. And she'll come in and we talk a lot.

For individuals who are mostly confined to their room, one-on-one socialization with visitors is the only option. Helen, who at age 92 is slowing down in mobility and energy, also expressed that her only socialization happens when someone comes to her room. She explained, "Five years ago I was out running around you know, but I'm not anymore. I just stay. If I know anybody new it's because they get by the door." If guests are unable or unwilling to leave their rooms, their socialization is limited to visitors who intentionally come to their rooms. For those who do not have family, friends, or friendly neighbors, isolation is a very real risk.

NUMBER THREE: ACHIEVING MEANING IN NEW RELATIONSHIPS

Strategies for building meaningful relationships

Guests were able to achieve emotional closeness with each other and meaning in their

relationships. They built meaningful relationships by spending time together outside of the scheduled activities, working together on tasks, navigating health issues, and conversing and sharing. Millie explained how she would spend time with another guest outside of the activities scheduled by the staff: “There'd be like a 50 or 60 inch TV, and she and I liked the same kind of movie. So I would take a bottle of wine, grapes, cheese, and crackers...I'd take microwave popcorn, and we just had a grand old time. Sittin there watching these old movies.” By spending extra time together outside of the scheduled activities, Millie and her friend were able to come up with an activity that they enjoyed and shared. They were each able to contribute to movie night by providing snacks and the TV or movie. Being able to contribute to an activity is important for some guests when developing meaningful relationships. Margaret explained how she worked with other ladies during Bingo, which eventually led to them sitting together regularly. “When she sat at the table, I said, ‘If I sit at the table here, would you want me to help you with the Bingo?’ She said, ‘Oh yes.’ That was real good. She looked for me every time she would come in.” Going to the scheduled activities and working together with other residents help the patients foster new relationships. Lorena described how she helped another guest through a trying time in her health struggles.

> It makes me feel good knowing that it's helping them...Especially her...She wouldn't go out of her room. She didn't talk to nobody. She was constantly fussing at the aides. She's thrown I don't know how many nurses out of her room, until I started talking to her. I finally got her out of her room. I took her outside on the porch and we sat out there and we talked. We'd go out two or three times a day. She was in a wheelchair. Before she left, she was walking with a walker.

The relationship that Lorena described demonstrates how some residents perceive social support as important for improvements in both emotional and physical health, as well as for development

of meaningful relationships. Ruth told me how conversation and sharing with other guests is meaningful to her and makes her feel like she is making a difference. .

> Being a friend and sitting and listen to them talk, and sometimes hear the frustration in their voice and being able to comfort them by just being there and giving them time, taking the time to be there for them and listening to them...Like I'm needed in their life, that I can make a difference by being there for them and giving them space and let them complain about whatever they want.

It is clear that many guests achieved emotional closeness and derived meaning through these strategies.

Barriers to meaningful relationships

There were also times when emotional closeness was not achieved. This could be because a friendship existed and then went away (deteriorating health) or because there were challenges (personal) that prevented them from being close, even if the intent was there. Deteriorating health can be a major barrier to relationships in nursing homes, as described by Ruth here.

> Sometimes a challenge is people will have dementia and things like that, where they forget who you are or what you are, will react in a way that's not normal for them, and I have to remember to tell myself that's not who they are. They wouldn't say or do that if they were younger, if they knew what they were doing. So that's probably the biggest challenge, and I kind of defend people when they say or do something that's not for what we think the normal is.

Sylvia explains a direct experience she had with the deteriorating health of a close, new friend.

> I used to be friends with a lady in here that lived in here. She still does live in here. Her name was Ava. She and I was real good friends, real close friends. When you see one of us, you seen the other one, doing whatever. And she had a stroke...And when she had that stroke, she hasn't been the same Ava. I wished and wished and wished she'd go back to her way but she don't. She hasn't. It throws me because to see her acting so strange. I just can't. I can't visualize it, I can't understand it. I think, oh my god, when is she gonna learn. When is she gonna know. And how many times is she gonna do this before she learns? And I'm always saying things like that and I shouldn't do that. I love her to death. When I think about how close we were and how we are now, it about kills me.

Margaret, by contrast, did not describe close relationships with other residents, but instead explained how she mostly had surface level relationships, that have minimal emotional closeness.

> There's no real relationship. I see them maybe once a day, and that's about it, or when they have a picnic and we eat outside, I might see them there. There's no real connection there. It's not like, 'I'll see you tomorrow,' or, 'Don't forget, tomorrow we're going to bake cookies, and tomorrow we're going shopping.' There's none of that. It's just minimal...I just don't want to get that closeness, and I don't want to get myself upset again. It's happened too many times.

While there are many times when meaningful relationships can be achieved in nursing homes, it is evident that the fragility of health in later life is a major barrier. Some residents, such as Margaret, prefer to avoid emotional closeness due to what they perceive as inevitable pain and loss.

Discussion

According to socioemotional selectivity theory, our perspective of the time we have left in life (time perspective) decreases with age. When older adults perceive that their time left is limited, they increasingly become less knowledge-seeking and more emotion-seeking. In terms of social relationships, this means that older adults are more likely to focus on their closer and longer-lasting relationships, such as with family and spouses. There is more emphasis on improving those relationships and less on acquiring new friendships.

I found that most people staying in this facility described their most meaningful relationships as those with their families. Even if their current state of relations with their family was unfavorable, they still noted that these relationships were of great importance. Falling in line with socioemotional selectivity theory, older adults at this facility cared most about their emotionally salient relationships. They dwelled more on the positive emotions than negative.

Participants offered ways in which their families were able to provide emotional, financial, and social support. Participants spoke fondly of their visits with family and the ways in which they were able to adapt to long term care because of their family's support. However, many residents had family members that did not provide sufficient emotional support. The reasons why family members were not able to give enough support might have been the same reasons as to why the residents were institutionalized, such as living far away or not having a strong relationship. Even those who typically received family support pointed out instances in which they were not able to receive family support. The residents recalled and were bothered by the times in which family support was not available.

Family support is not always available, both for those who have engaged family members and those who do not. Especially as the role of women in the workplace continues to evolve and expand, there are less opportunities for American families to play the role of "caretaker" for their elderly family members (Bookman and Kimbrel, 2011). Residents who did have consistent family support still engaged in activities with other guests either to keep busy or because they enjoyed being social. For residents who did not have adequate family support, emotional ties had to be rooted in new relationships. Otherwise, they would risk isolation in their rooms. Residents who did not have adequate family support but sought support from other residents did so primarily if they had an interest in being social and were healthy enough to leave their rooms. Importantly, residents utilized specific strategies for getting to know other guests, such as participating in activities, introducing themselves, and going the extra mile to interact with other guests. Socioemotional selectivity theory might posit that older adults do not seek "knowledge

acquisition." However, my research suggests that older adults might tolerate knowledge acquisition under certain conditions and if it leads to emotionally meaningful relationships.

Older adults might be more willing to seek new relationships if they live in a nursing home. Not only are new relationships with others in the same age cohort readily available, but they can also help residents become more accustomed to daily living in a facility. Being able to participate in social activities, such as the daily Bingo game at this particular facility, can provide structure and familiarity for residents. Older adults, specifically those who live in nursing homes, also may be more willing to foster new relationships when they do not receive sufficient social support from long-lasting relationships. At this stage in life, emotional closeness is a priority, and residents of nursing homes seek to establish social support in some way. The task for nursing homes is to provide opportunities for social support to be established among residents. However, most nursing homes are set up to protect residents from health risks, and not necessarily to facilitate social support or resident satisfaction. Instead of focusing solely on medical care, there needs to be a shift in focus to the "emotional closeness" factor, which is so important to older adults. Dr.Atul Gawande offers that patients should be treated on a more individualistic level, placing emphasis on the desires of each patient, which often includes having a greater sense of purpose outside of the mundane tasks of institutional life and medical care. The participants in this study suggested that activities that allow them to connect with others, such as helping other residents and conversing with them, can provide a sense of individuality and purpose.

Participants offered several ways in which they were able to establish new relationships. Most of the new relationships were established through activities set by the institution, while some took the extra steps to meet people on their own. They also explained how they derived

meaning from these new relationships. Although the relationships were not particularly long lasting, they were still able to form a sense of reciprocity and sharing. Activities that fostered reciprocity and sharing included working together on activities, conversing about their families and personal challenges, and spending extra time helping each other. They were able to help each other, from the minimum of preventing isolation to the maximum of helping them achieve wellness and good health. These findings support the existing research that social support can minimize the impact of stress on mental health, can improve physical health outcomes, and can increase overall well being and life satisfaction in older adults.

Limitations

This study has a few limitations. I only interviewed residents at one skilled nursing facility, and used a non-random, snowball sampling approach. In the future, this study could be expanded to include other facilities which may have different environments for the fostering of social relationships among residents. Another limitation is that participants were introduced to me by the activities staff, so I mostly spoke with guests who were known by these staff members due to their participation in social activities. It is likely that I was not able to talk to some residents who were unable or unwilling to attend structured activities. I also primarily interviewed residents who were willing to talk with (in many cases) a stranger, so by nature these participants might be more friendly and social than other nursing home patients. By engaging with less social older adults, further studies could explore the predictors and outcomes of limited social support. I also talked to residents who were mostly healthy, and probably had a longer perspective of the time they had left in life than some other patients. They might have been more likely to build new relationships since they did not perceive the end of their life to be imminent. Lastly, my own experiences as a volunteer at the facility over the past four years have influenced

me to believe that meaningful relationships do take place in nursing homes, which likely shaped my finding that developing new relationships is meaningful to some guests.

Future Directions and Practical Implications

The future direction for this research project is to replicate it in other skilled nursing facilities. Other nursing homes might have different features such as shared rooms and common spaces, or different activities for socialization. Conducting this research in other locations will allow me to see if my findings are shared across different facilities and environments. There are several practical implications of my findings for this specific facility. First of all, residents should be given the tools to continue and/or strengthen their relationships with family. In this facility, residents are given telephones and have the ability to send and receive mail. There are no limits to visitation hours, and families are able to reserve larger rooms for gatherings. These practices should be continued and supported. Secondly, those who are able to and choose to participate in social activities with other guests can be given resources to improve their interactions, such as conversation guides. Activities should engage those who are not overly friendly, and provide time for guests to talk if they wish. For residents who are unable or do not wish to participate in group activities, there should be ways to ensure they are not socially isolated. Some suggestions are having a neighbor check in, create a peer-to-peer buddy system, or have staff provide one-on-one support. Coordinating volunteers to visit with guests who are confined to their rooms may be another avenue for providing social support. Nursing homes may be able to work with nearby institutions such as schools, churches, and community organizations to set up volunteer programs. Lastly, meaningful relationships should be fostered whenever possible. Although the deteriorating health and other personal challenges of the residents is a

challenge that can't be controlled, there are still ways to develop emotional closeness for those who wish to do so. Staff can develop and promote programs that work on relationship building, sharing, and conversation when able. At this facility, there are several activities that emphasize these points, yet are not well attended. There are also activities that are very well-attended, but do not currently provide opportunities for fostering close relationships. Given the popularity of the daily Bingo game, staff might consider ways to promote conversation for a couple minutes before and after the game. It is important to recognize that older adults do find value in building new relationships with other residents, and that resident interaction can be meaningful. Nursing homes can support the value that residents find in establishing emotional closeness with other guests by trying to understand the ways in which their residents prefer to develop social support and the ways in which residents experience barriers in building new relationships.

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